# C A R E  Bal Bachau

(Child Survival in Nepali)
Cooperative Agreement No. GHS-A-003-00014-00
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## CSXIX Expanded Impact Category

# Mid-term Evaluation


Consultant: Babu Ram Devkota

CARE HQ Contact:
Dr. Khrist Roy
Technical Advisor Children's Health
Health Unit
CARE USA
151 Ellis St. NE
Atlanta, GA 30303
Tel: 404-979-9434
Email: kroy@care.org

CARE Nepal Contact:
Alka Pathak
Country Director
CARE Nepal
P.O.Box 1661
Kathmandu, Nepal
Tel: 977-1-5522800
Email: alka@ carenepal.org


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## ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Ante Natal Care |
| ANM | Auxiliary Nurse Midwife |
| ARI | Acute Respiratory Infection |
| BCC | Behavior Change Communication |
| CBO | Community Based Organization |
| CB-IMCI | Community Based Integrated Management of Childhood Illness |
| CDD | Control of Diarrheal Disease |
| CDP | Community Drugs Program |
| CHD | Child Health Division |
| CHS | Community Health Specialist |
| CS | Child Survival |
| CSHGP | Child Survival and Health Grants Program |
| DHO | District Health Office |
| DHS | Demographic Health Survey |
| DIP | Detailed Implementation Plan |
| DPHO | District public Health Office |
| EIC | Expanded Impact Category |
| FCHV | Female Community Health Volunteers |
| FCHV-CC | FCHV Coordinating Committee |
| HF | Health Facility |
| HIDN | Health, Infectious Disease, Nutrition |
| HMG | His Majesty's Government |
| HP | Health Post |
| HQ | Headquarters |
| HW | Health Worker |
| IEC | Information, Education and Communication |
| IMCI | Integrated Management of Childhood Illness |
| INGO | International Non-Governmental Organization |
| KPC | Knowledge Practice and Coverage |
| LOE | Level of Effort |
| LMD | Logistic Management Division |
| LQAS | Lot Quality Assurance Sampling |
| MCHW | Maternal Child Health Worker |
| MG | Mother's Group |
| MMR | Maternal Mortality Rate |
| MNH | Maternal and Newborn Health |
| MOU | Memorandum of Understanding |
| MOH | Ministry of Health |
| MTE | Mid-term Evaluation |
| NEPAS | Nepal Pediatric Society |
| NGO | Non-Governmental Organization |
| ORS | Oral Rehydration Solution |
| PCM | Pneumonia Case Management |
| USAID | United States Agency for International Development |

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A. Summary

*1. Program Description and Objectives*

CARE Nepal has been implementing a four year Child Survival Project (CSP) from October 1, 2003 to September 30th, 2007 in four districts namely, Kanchanpur, Doti, Dadeldhura, and Bajhang of Far Western Region (FWR) of Nepal. The program is being implemented in partnership with the Ministry of Health (MOH) and Non-governmental Organizations (NGOs) under the USAID/GH/HIDN/CSHGP new Expanded Impact Category (EIC) based on the Community-based Integrated Management of Childhood Illness (CB-IMCI) framework.

Initially, CARE Nepal had implemented a four year CS project in the Kanchanpur district, in the *terai* (plains,) beginning from October 1999. After the successful implementation of the project in Kanchanpur district, the project has been expanded to the three other hilly districts of Doti, Dadeldhura, and Bajhang. The new districts were selected after consultation with the Ministry of Health (MOH) and criteria for selection included the remoteness, lack of infrastructure and low level of female literacy as indicated by census data.

The total target population of the project districts is 931,054 of which 146, 514 are children under the age of five and 60,465 are pregnant or lactating women, making a total of 173, 181 people that benefit directly from the projects. Other beneficiaries include the 227,200 women between the ages of 15 and 49, who are approached through the Mother's Group (MG) for Health Education and other women group activities. CSP works with 2332 MGs which are important to the project's Behavior Change Communication (BCC) strategy regarding child survival interventions. The project aims to strengthen all 148 health facilities in the districts, 558 outreach facilities, 2332 FCHVs and 8 local NGO/CBO partners.

Project efforts for CARE Nepal's Child Survival Project are distributed between control of diarrheal disease (CDD), pneumonia case management (PCM), maternal and newborn health (MNH), micronutrient intervention (Vitamin A and Iron and Folic Acid (IFA) and malaria. Out of these MNH and malaria are interventions are in the Kanchanpur district only. The major interventions and the level of the effort spent for each intervention in the project districts during the project period are presented in the following table:

| District | % of Effort being spent | | | |
|---|---|---|---|---|
| | Micronutrients | CDD | PCM | MNH |
| Kanchanpur | 25% | 25% | 25% | 25% |
| Doti, | 35% | 30% | 35% | - |
| Dadeldhura | 35% | 30% | 35% | - |
| Bajhang | 35% | 30% | 35% | - |

There are four program objectives of CARE's *Bal Bachau* (Nepali for Child Survival):

Objective No.1, Access to Services and Supplies: Families have increased sustainable access to health education, quality health care services, and essential medicines at the community level.

Objective No.2, Quality of Care: Community level MOH personnel, Female Community Health Volunteers (FCHV) and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI intervention areas.

Objective No.3, Behavioral Change: Caregivers of children under five years of age practice healthy behaviors and seek medical care from trained sources when needed.

Objective No.4, Building Local Capacities: Local and community-based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis.

## *2. Main Program Accomplishments*

### *Methodology of the Mid-term Evaluation (MTE)*

The MTE was very participative; it included team members as representative from MGs, FCHVs, FCHV-CCs, HW, DPHO medical officers, local NGO partners, NGO partner from Kathmandu, Regional Health Office, CARE- CSP staff from the district, region and Kathmandu office, CARE-USA backstop and local USAID mission representative. The actors and players who were interviewed were the Mother's Group, FCHVs (*dalit* and non *dalit*), drop out FCHVs, DHOs, Health Facilities, HFMCs, Dabi group (*dalit* and non *dalit*) partner NGOs (a total of 4) PAC members, Municipality Officials in Kanchanpur and FCHV-CCs. The debriefing at Kanchanpur was done by a team of two to three people, one representative of DPHO, the other a FCHV or MG member and the third one from the local NGO or CSP staff. At Kathmandu the debriefing was done by the Regional Health Office official, by the consultant, CSP PM, CARE-USA backstop and CARE-Nepal representatives

Pre-workshop activities:
The consultant, the CARE-Nepal health unit, CSP PM and his team and the CARE-USA backstop exchanged e-mails and telephone conversation to delineate the following in regards to the MTE.

a) Review of DIP, AOP, annual reports and related documents.
b) List the key stakeholders that need to be interviewed/assessed.
c) List possible invitees who would then be possible evaluation team members.
d) Discuss the tools to be used for the MTE.

e) Discuss training site, logistics, and team composition for each district with identified team leaders.

The MTE training workshop was held in Kanchanpur district on December 28th and 29th 2005. The activities carried out in the workshop were

1) Design and validation of the interview guides.
2) Selection of key informants to interview and communities for assessment activities. A total of 13 in-depth-interview/FGD, field observation and consultation tools were designed for the MTE.
3) Training session on how to conduct key informant interviews and focus group discussions were conducted, with small group discussion and role plays done to gain clarity and confidence.
4) A logistics team finalized plans.
5) The MTE divided into 4 groups and conducted MTE by district. Fieldwork took 5 days as planned. Bajhang which has road and transport difficulties finished later.
6) Each district MTE team then conducted participatory analysis and presentation of key findings during 5 more days.

Two final presentations were done, incorporating key findings and recommendations from all districts. One was for the benefit of local partners and was done in Kanchanpur. The national level presentation was aimed at the national MOH, other national NGOs and the local USAID mission.

*Key Findings*

Mr. Shiva Dutta Bhatta, a public health officer and Regional Health Director of the Far West Region of Nepal shared during the regional and national MTE de-brief meetings that Kanchanpur district scored the highest in Nepal on a consolidated child survival indicator. This indicator is calculated by the national MOH. Over the last five years, Kanchanpur has improved its position from 22nd place to 1st out of 72 districts in the entire nation. Mr. Bhatta also observed that the three other districts were improving their performance.

As indicated from key informant interviews across the groups of partners and from general observation of the consultant, the CSP team members have displayed excellent working relationships with each other and with staff from partner organizations.

By the mid-term, the project has implemented the Community Based Integrated Management of Childhood Illness (CB-IMCI) in the three new districts of Doti, Dadeldhura, and Bajhang. In addition, the project also completed the scheduled CB-IMCI complementary activities: (i) Health Facility Management Committee (HFMC) strengthening program (ii) Female Community Health Volunteers (FCHV) strengthening program and (iii) Mother's Group (MG) extension program. The task of multi-sectoral collaboration, linkage building, and outreach to communities has been mostly completed in Kanchanpur and is moving ahead in the three other districts. However, approximately 35 percent of the planned Detailed Implementation Plan (DIP) activities have not been

completed due to the country's security situation (annual report 2005, page 5, last paragraph; MTE consultant observation confirms).

This project has already achieved many of the targets that the project aimed to attain by the final term. For instance the project team has met their goal of percentage of mothers of children 0-23 months who know at least two signs of childhood illness has exceeded end of project (EOP) target of 85% for Kanchanpur at 95% during recent LQAS, and for the 3 remaining districts, indicator is at 84%, beyond the target of 80%. Similarly percentage of sick children in the 0-23 year age group receiving increased fluids and continued feeding has exceeded EOP target of 65% for Kanchanpur at 89%. Among these children, the percentage who received continued breast feeding during the illness exceeded EOP targets of 90% in Kanchanpur at 94%, and in the other 3 districts it has increased to 84%, exceeding the EOP target of 75%. Similar success is noted in access to IFA tablets with pregnant women obtaining at least 90 tablets while pregnant (77% at LQAS, exceeding the EOP target of 55% in Kanchanpur; and 32% in the 3 other districts, exceeding EOP target of 20%).

This project works with 2332 Mother's Group (MG), including the MGs that work with project partners (NGOs and CBOs supported by CARE), along with those that CARE supports directly. The project works in these groups to inculcate behavior changes in the community, especially related to maternal and child health. Many MGs have matured and are able to identify and plan their activities without any support. The CSP has phased out of locations where MGs have achieved independence and is planning to phase out from more areas where the MGs have developed a sense of rights and empowerment as displayed by the activities undertaken without supervision (although regular monitoring is still done. MGs are active participants in the four CSP districts; however, as expected some are not as much independent with their work in the 3 hill districts, especially in Bajhang. The CSP and partner NGOs need to focus more attention on those geographic areas where MGs are weak. Similarly, an important MTE finding is that although a lot of ground has been covered to reach the *dalit (*literally the downtrodden, a modern self defined political coinage as an umbrella group of the lower castes*)* mothers in the community, more directed efforts need to be made by the CSP and partners, where CSP takes the lead in assuring greater inclusiveness of the *dalits* as part of a Rights Based Approach (RBA) to health.

*Community Drug Program*

The Community Drug Program (CDP) has been successful in Kanchanpur and health facilities are now able to provide essential drugs at an affordable cost to a wide variety of patients at any given moment regardless of what they can afford. CDP entails the health facilities buying quality essential medicines in bulk at cheaper prices and selling it to the patients at a small profit. This success needs to be replicated in the three other districts.

*Connection between Health Facilities and Community Organizations*

The CSP staff have observed that different platforms and agencies working towards women's and children's health have joined together to take a broad look at the problems and solutions. CSP review meetings attract participants from MGs, FCHVs, MOH, MOE, CBOs, NGOs, and local administrative units like the village development committees (VDC) and the Health Facility Management Committee (HFMC) to come together to identify problems and solve them.

*Dabi Groups* (literally "claiming rights" in Nepali language)

Started initially as a dedicated effort to raise consciousness about *dalit* related discrimination issues, this movement has grown into an all encompassing movement for claiming rights for women and at times for the entire community. The greatest enthusiastic support that *dabi* groups have been able to engineer is the eradication of the '*chaupadi'* tradition, which refers to the practice of exiling women during menstruation and/or following child birth to an animal shed. This practice in 68 *dabi* groups in the project area has ceased to exist and women are enjoying not only a tremendous sense of freedom from oppression but also a great sense of achievement and empowerment which is launching them into newer areas of 'claiming their rights'.

*HMIS*

A community based Ministry of Health (MOH) monitoring system is in place. Female community health workers compile data on their services and share them with MOH staff, the Village Health Development Worker (VHW), and the Maternal and Child Health Worker (MCHW). This project with MOH staff and other partners also plan to conduct two surveys a year to monitor progress in achieving goals. These surveys employ the lot quality assurance sampling (LQAS) technique and generate information for about 4 to 6 field supervisory areas in each district. Project partners then discuss findings, identify problems, and recommends remedial action.

Additional CSP activities in the more advanced Kanchanpur area have also been successful. CSP Kanchanpur has piloted the PD Hearth approach for malnourished children and to date has rehabilitated 296 severely malnourished children through this approach after training18 FCHVS and running 18 PD Hearth centers.

CSP Kanchanpur in collaboration with MOH, Nepal Family Health Project and the related HFMCs has successfully made operational 4 laboratory centers for the diagnosis of malaria in Kanchanpur and thus has answered the felt need and request of the local population. CSP Kanchanpur has also trained FCHVs on the MNC component. This has resulted in increased number of child births to be attended by a trained health provider, increased TT coverage, increased consumption of IFA and increased consumption of Vitamin A by the mother, post delivery.

### *3. Progress in Achieving Program Objectives*

The CSP's progress by objectives is given in the table below:

| Objective | Progress | |
|---|---|---|

| | toward Target | Summary of extent of progress towards the target (For details please see text) |
|---|---|---|
| 1. Access to Services and Supplies: Families have increased sustainable access to health education, quality health care services, and essential medicines at the community level | Yes | Progress in all project targets (with the exception of Bajhang district) and some indicator targets have been reached. Scale up of the community drug program after recommendation from the RAC to the 3 other districts is recommended. CSP might also consider the LRP as a possible stock list of supplies in difficult to reach areas |
| 2. Quality of Care: Community level MOH personnel, Female Community Health Volunteers (FCHV) and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI intervention areas. | Yes | Most MGs know the danger signs of childhood illnesses.<br>Most FCHVs and HW have the correct knowledge to identify pneumonia and dehydration in diarrhea.<br>CDP is a success in Kanchanpur and most HF have adequate stocks of essential medicines excepting IFA. |
| 3. Objective No.3, Behavioral Change: Caregivers of children below five years of age practice healthy behaviors and seek medical care from trained sources when needed. | Yes | 1) As BCC at the grass-root level, there is evidence that MGs are actively involved in the entire project.<br>2) As a defined strategy by partners, the 3 districts besides Kanchanpur are lagging. |
| 4. Objective No.4, Building Local Capacities: Local and community-based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis. | Yes | 1) Local capacities with the MGs, FCHVs and local health facilities are very high.<br>2) Local capacity building of local NGOs/CBOs need strengthening.<br>3) The capacity of the local MOH to respond to reported stock outs in the community for essential medicines can be improved. |

*4. The main constraints, problems and areas in need of attention*

*Areas that need attention*

The areas that need special attention and a balanced approach to interventions are:

- CSP has fallen behind schedule and that is explained due to the security issues related to the insurgency in the rural areas, more so in the remote rural areas. Bajhang district is lagging the most amongst the 4 districts and special efforts need to be made to improve its performance.

- BCC efforts for the 3 hill districts of Bajhang, Doti and Dadeldhura need to be scaled and speeded up.

- Given the unpredictable, ongoing and recurrent set backs due to the security situation, It is unlikely that the project will be able to come out with a viably sustainable model in the remaining project time especially in the less well performing district of Bajhang.

- The approaches for strengthening of HFMCs, VDCs FCHV, CB-IMCI approach, MGs PCM, and CDD have shown particular success and these models should be shared widely with partners and other organization. In

Kanchanpur, pilot activities for CDP and PD Hearth have shown success and should be considered for expansion. An excellent tool for scale up and/or expansion can be cross-visits, in either direction, from the 3 districts to Kanchanpur or from Kanchanpur to the 3 districts.

- CSP should prioritize the recent private donation received through CARE for the basic training of new FCHVs and hand in hand try to re-recruit the FCHVs that had dropped out.

- Communication between the FCHVs and the local MOH should be further strengthened as seen through the lack of Cotrim, ORS, IFA etc in the community, whereas ample stocks were available at the district level.

*Political and Security Constraints*

Current security situation at the project districts: Nation's security situation is very serious and challenging. All governmental service delivery institutions (partly health) are not functioning optimally and thus, centralized at district head quarter. Developmental activities of INGOs (including CS XIX) in collaboration with government counterpart and civil society are not in full fledge functioning.

Despite of this situation, the project has done considerable effort to work in conflict in a strategic way. Staff security at field, district and working station is CARE concern and handled without any compromise/risk. Conduction of regular project meetings, to understand and adapt the working strategy at district and region has been a proven strategy to build staff morale and confidence to work in conflict. Furthermore, a CARE security point person at district and region provides regular updates on the situation.

In this reporting period, CS XIX has maintained a low profile and visibility in the field. CS security preparedness strategy is: A CARE security manual is distributed to all staff and they receive orientation to CARE Nepal assessment of the situation and approach to fieldwork. Field staff are given authority to make logical decision on security matters at any location. Staff is trained to use "Do No Harm framework" to maintain transparency, impartiality and neutrality. Partnership with local institution and local staff at project/partner organization has decreased the risk. Transparencies in programming and participation of civil society in project implementation and progress review have proved to be successful approach.

Working in conflict has delayed implementation of the project as was desired. However, the recent political changes in the country seem very encouraging and could lead the project to meet the desired goal that the project has stated during the DIP preparation.

The absence of elections for local government Village Development Committees since July 2002, has decreased the functional capacity of VDCs, although they continue. This has caused some limitations to local developmental activities. In many instances, VDC annual budget is under expended.

As the Village Development Committee (VDC) Chairperson is usually also a chairperson of most of decentralized management committees, such as HFMC & CHMC of health, these committees are not functioning as planned. Health Facility Management Committee, Community Drug Management Committee, and FCHV endowment fund committee are facing problems of resource allocation, making decisions and program evaluation. Likewise, coordination, collaboration and linkage with local networks are also highly affected.

*FCHV Drop out & Basic Training*

During the MTE 43 FCHV drop outs were consulted. The major reasons of drop out were reported to be associated with migration, and unwillingness to work in a few cases. Also, non-literate FCHVs were discouraged by some health staff from getting involved in CB-IMCI. Drop out FCHVs were found at MTE to still expressing their willingness to work if they get an opportunity to be involved in the program.

DHO records shared with CSP show a total of 445 FCHV drop-outs (Bajhang-192, Doti-127, Dadeldhura-84 and Kanchanpur-42). The drop out rate in the hill districts ranges from 18% to 45% (Bajhang-45%, Doti- 20% and Dadeldhura- 18%) which is very high considered to national average. Because of the current security concerns particularly in the hill districts, this was as expected. The drop out rate in Kanchanpur is relatively low (5 %) which is similar to national figure. CSP is actively working with the regional, district, and local MOH officials and MGs to stop the dropout rate and actively follow-up with previously trained FCHVs to reinvigorate their role. The project needs to explore possible collaborations for FCHV and drop out FCHV needs.

*Project and district specific constraints*

This section discusses (a) constraints, problems, areas of attention for the whole project, and factors that are not necessarily under direct project control; (b) Mentions problems and constraints for Kanchanpur district, as it has had greater exposure since 1999; and (c) similar issues that have been discussed in regard to Doti, Dadeldhura, and Bajhang.

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*Issues for the entire project*

- Ministry of Health staff members at the district office and health posts are frequently transferred. This disrupts programmatic decision making and relationships with community members. As MOH staff transfer is a central government issue and is likely to be an impediment in all CARE projects, CARE Nepal should seize the initiative at the national level with other national NGOs who are working in the health sector and recommend or advocate for a carefully crafted MOH transfer policy.
- The evaluation team found that health facilities and community-based health workers face shortages of some medicines and other commodities. Cotrimoxazole, Oral Rehydration Solution (ORS) packets, and Vitamin A (for administration to women after delivery) have been out of stock. As indicated by MTE findings, there was no shortage of the essential medicine at the

health facility or district level, with the sole exception of IFA, The shortage, therefore appears to be a lack of communication or coordination between different levels of the MOH. CSP and its local partners should work at all levels of the MOH to help improve communications.

*Doti, Dadeldhura, and Bajhang districts*

- Due to security concerns and thereby the difficulty in going and working in the periphery the NGO partners and CARE have been 'squeezed in' to work in the same areas which at times results in duplication of work, especially at the level of interaction with the HW. More coordinated planned efforts between the local NGOs and CARE will be needed to reduce this level of duplication.

*5. A summary of the capacity-building effects of the program*

This project has the capacity to deliver and track healthcare services at the community level and of health facility, partner NGO, and CARE staff.

- At the community level 225 HW have been trained on the clinical or CB-IMCI. A total of 885 FCHVs have been trained in CB-IMCI as per the government of Nepal's standard protocol.
- Supportive supervision has been institutionalized and is now carried out regularly. Of all HW and FCHVs interviewed, all HW (excluding Bajhang) the supervisory visits were near 100%. For FCHVs also supervisory visits were very high. The system now regularly uses supervisory checklists.
- The project has benefited from LQAS training in which 43 MOH and 21 local NGO partners were also trained.
- BCC training for Kanchanpur district has been accomplished and was facilitated by an external consultant from and a BCC strategy was formalized together with key players like the MOH and the local NGO partners (Attachment H). A BCC concept paper was produced after the workshop for Kanchanpur district.
- CARE CSP staff and partners received exposure to different trainings and workshops at local, regional, national and international level. Some highlights include:
    - Along with the CS Project Manager, the Nepal MOH Regional Director for Health for the Far East participated in CARE's 10th Annual Child Survival Workshop from the 18th to the 22nd of April, 2005 held in Malawi, Africa. Important lessons learnt by means of supportive supervision, community driven scorecard approach was much appreciated and a workshop was conducted by the Regional Health Office (MOH) to assess the feasibility of incorporating it in the entire region of Far-West region.
    - The CSP RMDS officer participated in and EPI-Info regional workshop from the 18th to the 22nd of April, 2005 in Uganda organized by CORE Group and Makerere University, Kampala, Uganda. He has been using these skills for program monitoring and evaluation since then.
    - Training Specialist (TS) accompanied by CARE Nepal's RBA core team underwent a Right Based Approach (RBA) and Advocacy Training in India

from the 15th to the 25th of December 2004. Both candidates have been contributing their skills in facilitating the RBA initiatives and the monitoring and evaluation. Since then, almost all CS staff has been trained in human right-based approaches which covered the analysis of fundamental human rights and evidence-based advocacy and issues identification advocacy.

*6. A summary of the prospects of sustainability*

The CSTS, the local USAID mission in Nepal and CARE have come together to assess the project's sustainability in terms of the CSSA frame work. Technical support is being provided by the CSTS. Using these measures, the CS XIX has improved the availability of CB-IMCI services considerably and be able to visualize the progress of its sustainability strategy.

Formation or reinvigoration of Health Facility Management Committees, Health Facility Operating, and Management Committees, Female Community Health Volunteer Coordination Committee (only in the Kanchanpur district) and skill building of the FCHVs, HWs, MGs, *dabi groups,* and building capacities of local NGO have been the core foundation for sustainability. Advocacy and lobbying to Village Development Committee (VDC) and the general public for health consciousness are other approaches that have been made toward project sustainability.

As of now, two VDCs of the Kanchanpur district have already phased out and only monitoring is carried out by CSP in these areas. Similarly, in five other VDCs the process of handing over roles and responsibilities is currently being undertaken and will be completed by the end of first quarter of 2006. Further, within the sustainability framework, the project is developing a plan to disengage which includes three dimensions a) health and health services, b) organizational capacities, c) and community and social ecological dimensions

*7. Conclusions and Recommendations Resulting from the Evaluation*

For the project, the following list of actions has been recommended by evaluators for the remaining project period.

1. *Kanchanpur*
   a. Organize capacity building training for partner NGOs and FCHV-CC for organization development and strengthening.
   b. Continue to strengthen rights-based approaches and encourage FCHVs to further target *dalit* and marginalized clusters through MG meetings
   c. Strengthen the district level NGO and FCHV-CC networks and link them with other stakeholders to access resources
   d. Document best practices and transfer of learning to other CSP districts and to the larger CS community in Nepal. Greater impetus to be given to cross-visits for learning within the districts.

e. Provide facilitation and skills training to NGOs and FCHV-CC to ensure meaningful participation of the *dalit* and marginalized

2. *Doti, Dadeldhura, and Bajhang*
   a. Develop new and clear terms of reference with NGO partners to gain clarity and assist them to conduct organizational assessments if desired, and to develop action plans.
   b. Project staff should explore the possibility of incorporating local dialect in the training facilitation (and training materials, if feasible). As trainers are available locally and some CARE CSP staff is from the local area and are fluent in both the national language and local dialects, training can easily be conducted in the local dialect.
   c. CARE should look for a way to better influence national policy and implementation of policies. Strategies could be to form a national advisory group to review project progress and provide support, with the forum including representatives from the Ministry of Health (Child Health and Family Health unit and the unit that is responsible for improving neonatal survival), CARE (Katmandu and Doti), and USAID Nepal. Organize meetings of the advisory group every six months (shortly after each lot quality assessment). CARE could also explore possible CS NGO forums with other child survival actors.
   d. For M&E feedback and use, use a short list of indicators in discussions with project partners. CARE staff should identify one or two indicators within each technical area in consultation with the partners, giving special attention to indicators on which there has been slow progress during the first half of the project.
   e. The drop in completed immunization rates for the 3 other districts needs to be investigated, ascertained, and remedial action must be taken.

*8. CARE's Response to the MTE Evaluation Recommendations*

CSP will undertake to build the capacity of NGOs/CBO and the FCHVs especially in terms of social inclusion. The activities will be carried out primarily by the AICBO and be completed by March 2007. CSP will build capacities of the local NGOs regarding their concerns for being able to tap other donor funds and ensure that the organizational development strategic plans are implemented by March 2007 for all the 7 NGOs.

CSP will encourage the FCHVs to have a more inclusive approach which is in support of *dalit* pro marginalized section of the village/community population to be included in Mother's Group. This activity will be primarily done by the health supervisors and should be completed by December 2006.

Best practices of the project need to be documented. The project documentation officer is expected to write drafts of at least six best practices, three from Kanchanpur and at least one from each district and will be supported by the Project Manager in this regard.

Roles and responsibilities of NGO partners and CSP need to be absolutely clearly defined, primarily in the areas of previous security concerns, so that there is no duplication of work. The Project Manager will review the current MOU/TOR and work to modify ones that are required; this would be done by February 2006.

In order to address issues which cannot be resolved at the regional level, for example frequent transfer of health staff which leads to loss of trained personnel for the project, CARE- Nepal will explore advocacy possibilities, such as forming a national advisory group or forming/joining existing forums with other NGOs working on child survival with similar acclaimed vision and objectives.

CSP will take the lead in training the HWs and FCHVs in the local dialects and explore the possibilities of recommending local dialects for BCC materials produced by the partners in the future. These initiatives will start from June 2006.

For conducting the LQAS CSP will work choose a smaller list of indicators, mostly built around the 'Rapid Catch' or a few other indicators that the project's M&E frame-work requires. CSP will verify both the validity of the LQAS result by revisiting the analysis and also will cross-verify with district level secondary data to confirm or reject the finding. If indeed, the completed immunization rates are low then corrective managerial measures will be recommended by the PAC to be implemented in the field.

In order to ensure that the recommendation made during MTE to be followed for the better performance of the project, the CSP has also envisioned the activities to be carried out by different level with the deadline.

*B. Assessment of progress made towards achievement of program objectives*

As revealed by the data in the project M&E logframe (Table 2 below), on an average the overall project indicators either are close to or have slightly exceeded the target or are seen to have progressing trends in the project districts for all major intervention. Table 2 provides comparative data on the progress of major interventions in Kanchanpur and other project districts of Doti, Dadeldhura, and Bajhang.

Table 2. CARE Nepal Child Survival Project M&E Log-frame -- KPC Indicators

| ID | Indicator | Kanchanpur | | | Other districts | | |
|---|---|---|---|---|---|---|---|
| | | Baseline KPC | LQAS | Target for FE | Baseline KPC | LQAS | Target for FE |
| | | Aug 03 | May 06 | Sept 07 | Jan 04 | May 06 | Sept 07 |
| 1 | Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child | 68 | **89** | 80 | 75 | **68** | 80 |
| 2 | Percentage of children age 0-23 months whose births were attended by skilled health personnel (Note: Includes doctor, nurse, ANM, MCHW) | 24 | **31** | 40 | 10 | **29** | 40 |
| 3 | Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child (by card or reported verbally by mother) | 65 | **88** | 85 | 46 | **56** | 65 |
| 4 | Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours | 50 | **70** | 75 | 67 | **60** | 75 |
| 5 | Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours | 83 | **93** | 85 | 71 | **77** | 80 |
| 6 | Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday | 74 | **74** | 85 | 45 | **26** | 75 |
| 7 | Percentage of children age 12-23 months who received a measles vaccine | 87 | **88** | 92 | 69 | **75** | 80 |
| 8 | Percentage of children age 0-23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night | 2 | **21** | 25 | 0 | **NA** | NA |
| 9 | Percentage of mothers with children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and a after attending to a child who has defecated (washed hands in all four conditions) | 16 | **82** | 30 | 2 | **15** | 20 |
| 10 | Percentage of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment | 84 | **95** | 85 | 58 | **84** | 80 |
| 11 | Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks | 58 | **89** | 65 | 10 | **12** | 60 |
| | **Additional indicators from DIP (log frame)** | | | | | | |
| 12 | Percentage of children aged 6-23 months who received a Vitamin 'A' dose in last six months | 74 | **93** | 95 | 0 | **87** | 75 |
| 13 | Percentage of children age 0-23 months with diarrhea in the last two weeks who were continued breastfeeding during the illness | 84 | **94** | 90 | 68 | **84** | 75 |
| 14 | Percentage of children aged 0-23 months with diarrhea in the last two weeks who received Oral Rehydration Solution (ORS) and/or recommended home fluids (RHF) | 34 | **61** | 50 | 36 | **32** | 50 |
| 15 | Percentage of children aged 0-23 months with pneumonia in the last two weeks who were taken to health facility | 40 | **11** | 75 | 32 | **56** | 50 |
| 16 | Percentage of mother who received iron supplement (at least 90 tabs or 3 months) while pregnant | 26 | **77** | 55 | 6.3 | **32** | 20 |
| 17 | Percentage of mothers who received a Vitamin 'A' dose during the 45 days after delivery | 64 | **84** | 90 | 34 | **57** | 65 |
| 18 | Percentage of mothers with children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection | 38 | **67** | 65 | 10 | **28** | 65 |

During the MTE, additional process indicators from the project M&E logframe were assessed (Table No.3 below). Based on these findings, the level of performance is high in Kanchanpur district in comparison to the other three districts. CSP activities have had a longer period of implementation in Kanchanpur, thanks to the CARE Nepal CSP which preceeded this expanded impact program. It is to be noted that the sample size is small for making meaningful comparison for individual districts.

Table 3: CARE Nepal Child Survival Project M&E Logframe -- Process Indicators*

| Indicators | District | | | |
|---|---|---|---|---|
| | Kanchanpur | Doti | Dadeldhura | Bajhang |
| Increase % of FCHVs who have cotrimoxazole available with them for distribution. | 5/6 (83%) | 5/9 (55%) | 4/9 (44%) | * |
| Increase % of FCHVs who have regular supplies of ORS for distribution | 8/9 (89%) | 9/12 (75%) | 6/21 (28%) | 6/11 (55%) |
| Increased % of FCHVs who have supplies of IFA tablets for distribution | 3/9 (33%) | 0/12 (0%) | 3/21 (14%) | 0/11 (0%) |
| Increased % of mothers who are aware of FCHV's role in Vitamin A distribution during campaign | 25/25 (100%) | 25/25 (100%) | 42/42 (100%) | 21/21 (100%) |
| Increased % of FCHV that received at least one supervisory visit in the quarter previous to survey | 17/17 (100%) | 7/12 (58%) | 19/21 (90%) | 11/11 (100%) |
| Increased % of community level MoH staff (VHW/MCHW) that have received at one supervisory visit in the quarter previous to survey | 5/5 (100%) | 4/4 (100%) | 7/7 (100%) | 3/5 (60%) |
| Increased % of FCHVs who correctly knows how to diagnose pneumonia cases according to protocol (through cut off respiratory rate) | 17/17 (100%) | 7/8 (87%) | 8/9 (89%) | * |
| Increased % of MoH (HP/SHP staff) who correctly diagnose pneumonia cases according to protocol (through cut off respiratory rates) | 3/3 (100%) | 3/3 (100%) | 4/4 (100%) | 1/2 (50%) |
| Increase % of FCHVs who correctly knows correctly how to diagnose dehydration according to protocol (through two signs of dehydration) | 17/17 (100%) | 10/12 (83%) | 13/21 (62%) | 6/11 (55%) |
| Increase % of community level MoH (VHW/MCHW) who knows correctly to diagnose dehydration cases (through two signs of dehydration) | 5/5 (100%) | 3/4 (75%) | 7/7 (100%) | 5/5 (100%) |

Based on the secondary data from field observation gathered during the MTE, the project has been implementing much of the work plan in accordance to the Detailed

Implementation Plan (DIP) despite the conflict situation. The MTE has assessed the progress of the projects using different approaches and strategies. They include technical approach, cross cutting approach, capacity building approach and other strategies. They are discussed in the following chapters.

## Technical Approach

### *a. Project Overview*

The projects are located in three hilly districts, Doti, Dadeldhura, and Bajhang, and one plain districts of the Far Western Region of Nepal. The CS Project in the Kanchanpur district has been implemented since 1999. After the success in Kanchanpur in the previous phase, the project expanded to the Doti, Dadeldhura, and Bajhang districts from October 2003 for a period of four years with the goal of addressing issues related to child survival in the hill districts also by adopting experiences gained during the first phase.

The total target population of the project districts is 931,054 of which 146,514 are children under the age of five and 60,465 are pregnant or lactating women, making a total of 173, 181 people that benefit directly from the projects. Other beneficiaries include the 227,200 women between the ages of 15 and 49, who are approached through the Mother's Group (MG) for Health Education and other women group activities. CSP works with 2332 MGs which are important to the project's Behavior Change Communication (BCC) strategy regarding child survival interventions. The project aims to strengthen all 148 health facilities in the districts, 558 outreach facilities, 23322332 FCHVs and 8 local NGO/CBO partners.

Project interventions include micronutrients-Vitamin A, IFA, deworming and (Iodine Deficiency Disorders (IDD) taken as an extra pilot intervention on request of the community and MOH), pneumonia case management and control of diarrheal diseases. In addition the project also includes maternal and newborn care and malaria (Kanchanpur only). Project partners are implementing two complementary strategies to meet project objectives. First, the project is setting up a community based health information system that is linked to and supports the Ministry of Health services in the district. Second, partners are implementing the Integrated Management of Childhood Illness (IMCI) approach at the facility level and expanding the existing integrated community level approach (for management of diarrhea and pneumonia) throughout all project districts.

The goal of the project is to reduce child and maternal mortality and morbidity in Far Western Region (FWR) of Nepal. The project aims to assist the Ministry of Health to improve the health status of children under five and women of reproductive age in four project districts. The end objectives of the project are as follows:

Objective No.1, Access to Services and Supplies: Families have increased sustainable access to health education, quality health care services, and essential medicines at the community level.

Objective No.2, Quality of Care: Community level MOH personnel, Female Community Health Volunteers (FCHV) and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI intervention areas.

Objective No.3, Behavioral Change: Caregivers of children under five years of age practice healthy behaviors and seek medical care from trained sources when needed.

Objective No.4, Building Local Capacities: Local and community-based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis.

b. Progress Reported by Intervention Area

*Micronutrients*

There are three key interventions that CSP is implementing on micronutrients; these are IFA for the pregnant women, Vitamin A and de-worming.

The level of effort (LoE) for this intervention is 35% for Doti, Dadeldhura and Bajhang and 25% for Kanchanpur.

IFA consumption, promotion, and distribution are primarily for the pregnant and lactating women. This intervention has been implemented by DHO and local health facilities. DHO ensures that all of the health facilities are adequately and timely supplied. CSP role has been to promote maternal health messages through BCC strategies, Mother's Groups, strengthening the linkage between FCHVs and health facilities and Health Facility Management Committee strengthening.

Project baseline information on process indicators including the availability of IFA by Kanchanpur FCHVs was 68.7% and has declined to 33% during MTE. Similarly there has been a decline in the Doti, Dadeldhura and Bajhang districts, which are more remote, from 51.7% to 6.8%. (Please note that the sample size is small and that the sampling was not designed to be representative of the universe). Despite the low availability of IFA at the community level, the LQAS findings suggest that the access to IFA has exceeded EOP targets; this set of data probably indicates that a community level demand has been generated by the project's efforts and though the supply of IFA was intermittent, yet the consumption by the target group has been very high.

MTE assessment of project process indicators showed the availability of IFA by FCHVs to be the poorest performing component; however, BCC strategies for maternal health are likely to have contributed to LQAS findings of improved access, even exceeding

EOP targets by about 20% in Kanchanpur and by and 12% in the 3 other districts. The unavailability of IFA and other supplies at the regional level was attributed to frequent disruption in transportation because of the insurgent tactics. There are no changes in the technical approaches to improve IFA consumption recommended.

The situation was discussed at the regional and national level MTE exit meetings held in Kanchanpur and Katmandu. The MOH at the central level is now aware of this issue, has enough stocks for the IFA, and will take appropriate steps depending on the political situation of the nation and region. CSP will continue to work with the MOH based on the national guidelines. Also, CSP will encourage the MOH to use the Local Resource Person (LRP) to serve as a link between the FCHVs and the MOH health facilities for supplies and stocking concerns of FCHVs.

In Kanchanpur district Micronutrient International is proposing to launch a micronutrients initiative, CSP is likely to be a part of it with a specific role in monitoring and evaluation, especially of supplies at the FCHV and community level where its relative strength is best amongst the partners.

*Vitamin A and De-worming*

CSP actively participates in the national vitamin A campaign. Health education topics carried during the monthly meetings of MGs during this period (campaigns for Vitamin A are held twice in a year) focus on the importance of de-worming and Vitamin A.

In the baseline KPC assessment 74% children age 12-23 months were observed to have consumed Vitamin A in Kanchanpur, this has now improved to 93% during Mid-term. In other districts 87% children of the same age group were given Vitamin A. However, this indicator was not measured in the other districts during baseline. The findings have also shown increment in the distribution of deworming tablet in a substantially higher proportion both in Kanchanpur and other hill districts compared to the Baseline.

CSP is instrumental in mobilizing the community through its network of FCHVs and MGs in the four districts. CSP also contributes to the transportation logistics and staff time during the campaigns. There are no changes in the technical approach recommended. It should be noted that even during the turbulent times, all sides in the conflict have upheld the right's of the child to have access to preventative health aspects, so the campaigns have been very successful. CSP will continue to provide support to the national vitamin A campaign.

*Iodized salt*

Rampur VDC in Kanchanpur district was taken up as a pilot study for engaging all players in the marketing, distribution, storage, and consumption of iodized salt. The local health MOH officials, the traders, suppliers, marketers, and the community represented through the MG spokesperson had a tripartite talk which CSP helped

synthesize. Earlier, survey findings noted that the maximum loss of iodine in salt happened at the trader's storage facility. Talking to stake holders led to an intervention designed at containing the loss of iodide from the salt at storage facilities and all salt traders in the VDC were oriented to proper storage techniques by the project.

The regional project advisory committee in its next meeting will study the results and recommend future course of action for this intervention. CSP is likely to work along with Micronutrients International in this regards in the future, enhancing complementarities and assuring non-duplication of efforts.

*Pneumonia Case Management (PCM)*
The level of effort (LoE) for this intervention is 35% for Doti, Dadeldhura and Bajhang districts and 25% for Kanchanpur.

Pneumonia Case Management (PCM) is being implemented both through the CB-IMCI approach and the clinic IMCI approach. Nepal MOH approved the standardized IMCI and CB-IMCI training given to all participants. To further strengthen what is implemented, government clinics in Kanchanpur have started a community drug fund; medicines are purchased from the market and sold at a sliding scale profit scheme including free treatment for the poorest. FCHVs can purchase cotrimoxazole from the drug fund facility, sell it for a profit to a family whose child is identified with pneumonia at their house. This saves unnecessary trips and expenditures that the family would incur by traveling to the hospital.

At the health facility leve, training and follow-up is provided to the Ministry of Health workers at the health facilities and female community health volunteers (FCHV). Staff from the project and the Ministry of Health jointly supervises and monitors the HWs and the FCHVs. A total of 227 MOH HW have been trained in clinical IMCI at the time of the MTE.

At the FCHV level, the number of FCHVs who have received training is 885. The MTE assessment shows that the knowledge of the FCHVs and HW on signs and symptoms of pneumonia has increased from the baseline of 74% in Kanchanpur to 100% (17 FCHVs) exceeding the final evaluation target of 85% and for the other 2 districts (MTE unable to verify this indicator in Bajhang) has risen from a baseline of 31.6% to 88% (n = 17 FCHVs) exceeding the final evaluation target of 60%.

The FCHVs in the MG advocate behavior change of mothers in two ways: first, by educating the mothers and the community on how to identify whether the child has pneumonia or just a cold or cough and secondly, once that is learned by the group/community to advocate for early treatment at the community level through the treatment FCHVs who are mandated to keep cotrimoxazole and treat suspected pneumonia.

During MTE, the in-depth interviews/FGDs with the HW at all levels of health facilities said that the pneumonia control program is a very big success. They stated that, "The number of severe pneumonia or uncomplicated pneumonia seen in the health facilities has

dramatically dropped and now we rarely see pneumonia cases coming to the health system." They generally attributed this success to the two step approach which the project has been using, where it accessible at the community level drugs for the treatment of pneumonia and training of the FCHVs. The health workers also suggested that the training that they got for clinical IMCI has improved their capacities to deliver pneumonia related services.

At the community level, the key findings of MTE on PCM are bulleted as following:

- FCHVs knowledge on correctly diagnosing pneumonia case according to protocol, through respiratory cut off rate, has increased at the time of the mid-term, specifically, 32 FCHVs out of 34 FCHV correctly reported the respiratory cut off rate. The knowledge of health post in-charges with the same indicator also reached 100% in the three districts of Kanchanpur, Doti, and Dadeldhura. However, in Bajhang only one out of the two health post in-charge reported the correct cut off rate for pneumonia (Table 3).
- In Kanchanpur the availability of Cotrim at FCHV level was satisfactory (5 out of 6 FCHVs (interviewed) where as only about 50% FCHVs in Doti and Dadeldhura have been found having an adequate Cotrim stock (Table 3).
- As per the findings of Baseline KPC conducted in 2003 found that 84% (in Kanchanpur) and 68% (other districts) mothers of children aged 0-11 months knew at least two signs of childhood illness that indicate the need for treatment. The most recent LQAS survey for the same indicator showed 95% in Kanchanpur and 84% of mothers in the other three districts knew of at least two signs of childhood illness that indicate need for treatment . Likewise, percentage of children aged 0-23 months with pneumonia in last two weeks who went to a health facility dropped down to 11% in Kanchanpur while EOP target of 50% were exceeded by the 3 other districts to 56%. The drop down in Kanchanpur district can be read as a very positive finding, as now the children are getting PCM by FCHVs at their door-step and need not go to a health facility anymore. This trend is further substantiated by analyzing the secondary data of Kanchanpur where a consistent trend of increased PCM is seen to be done by FCHVs and a commensurate decline in PCM is seen by the health facilities.

It is suggested that CSP should work at documenting the MTE qualitative findings, of a decreasing number of children going to health facility for PCM as the FCHVs are now treating them at the community level, and less complicated cases (earlier care-seeking) seen among those who do seek treatment at health facilities.

*Control of Diarrheal Disease (CDD)*

The level of effort (LoE) for this is 30% for Doti, Dadeldhura, and Bajhang whereas for Kanchanpur it is at 25%.

Interventions are being implemented through the CB-IMCI and clinical IMCI approach. Training is under the Ministry of Health workers at the health facilities and is done for both

the HWs and the female community health volunteers in the community. Staff from the CSP and the Ministry of Health jointly supervises and monitor the HWs and the volunteers.

The baseline KPC survey found that 34% (Kanchanpur) and 36% (other districts) of children with diarrhea in the past two weeks received oral rehydration therapy or recommended home fluids. The LQAS assessment for the same indicator had increased to 61% in Kanchanpur, but remained at 32% in other districts.

In the baseline study, 68% of the FCHVs had Oral Rehydration Solutions (ORS) for distribution in the Kanchanpur district. The situation was improved at MTE to 88%. In Doti District, 9 out of 12 FCHVs (75%) had ORS for distribution, 55% of FCHVs in Bajhang but the availability of ORS in FCHVs in Dadeldhura is observed at 28%. The achievement for this indicator during the MTE as compared to baseline has been observed as substantially low in Dadeldhura (Table 3).

The mid-term evaluation team found that health facilities and community-based health workers face shortages of Oral Rehydration Solution packets, post-partum Vitamin A, and iron and folic acid (IFA). As reported by local health facility staff and the District Health Offices (DHO) the shortages are due to an increased demand as a result of the promotional activities carried out by the CSP in those communities. At the national debriefing meeting in Katmandu, Dr. Sun Lal Thapa, MOH of the Child Health Division, stated there is no shortage of ORS and Vitamin A at the national level, stating that regional stocks can be easily replenished. CSP must now develop systems which will enable the regional and national groups to plan and communicate the fluctuating needs of the regions. However, this also indicates that the CSP targets are being met as the demand generated increases.

The intervention has been effective and in the in-depth interviews of HW at the HF they say that the cases of severe dehydration are rarely seen by them. There have been no changes in the technical intervention and none are recommended.

CSP will continue to train the new FCHVs on CDD and will with the MOH continue to provide supportive supervision and develop systems to enable FCHVs to have stock available of ORS and other essentials. CSP should consider the LRP as its central strategy for all health districts, especially Bajhang for supplies and stocks due to the remoteness and absence roads in the district.

*Maternal and Newborn Health (MNH):*

This intervention is being carried out only in Kanchanpur with a 25% level of effort.

Under this intervention, FCHVs and health facility staff were trained in the key messages for maternal and newborn care, specifically concerning the education of pregnant women about the need for prenatal and postnatal care, tetanus toxoid vaccination, iron and folic acid, and post delivery Vitamin A supplements as stated in the national guidelines.

In addition to the community education, FCHVs also distribute iron and folic acid tablets, and clean home delivery kits in the communities where they worked, along with MOH approved family planning methods (oral pills and condoms).

During the baseline KPC assessment 24% of mothers in Kanchanpur reported that a trained service provider attended their last delivery. The proportion was found marginally increased to 31% in the 2006 LQAS assessment, (Table 2).

The percentage of mothers who had consumed Vitamin A within 45 days after delivery was 84% during the mid-term, as compared to 64% during baseline in Kanchanpur. In the 3 other districts, this increased from a baseline of 34% to 57% (Table 2).

Mothers receiving iron and folic acid (IFA) for at least 3 months (at least 90 tablets) during pregnancy were found to be 77% for Kanchanpur. The proportion for this indicator was 26% during baseline (Table 2).

During the in-depth interviews or FGDs, both, the Health workers and the FCHVs reported that the training on neonatal care to FCHVs was valuable. There have been no changes in technical approaches for the MNH component. CSP is expected to document the experiences on MNH in Kanchanpur so that the lessons may inform the future direction for MNH in Kanchanpur and be shared with the other 3 districts.

*c) New Approach*

*2. Cross-cutting Approaches*

*d.a Community Mobilization*

The **Community Mobilization strategy** focuses on Mother's Group as a center from which many other groups (such as savings and loans groups), institutions (like the FCHV-CC) and movements (like *dabi*), have grown. The other notable feature is that these aforementioned groups, institutions, and movements help increase the membership in the MG but also liven up the agenda, pace, roles and strengths of the MGs. The CSP has 2332 MGs in the four project districts in various stages of group formation. The Mother's Groups have been very active and have nominated possible FCHVs to receive basic and IMCI training to work in the community. Monthly MG meetings are carried out for consistent and continuous community mobilization. This is of singular importance to the CSP. FCHVs, members of the MG, and local NGOs are actively involved in these meetings. CSP staff and the MOH staff are peripheral to this activity but they support the meetings.

In the Kanchanpur district, the FCHV Coordination Committee (FCHV-CC) has become the face of MG activities. They are taking a very active role in the management of health facilities and their improvement. They are instrumental in building separate toilets for women in the health facilities where there were none. They have supported numerous MGs in initiating community level activities including improving the hygiene and

sanitation of the village members. MG has helped health facilities to look into priorities such as providing procurement and storage of snake bite anti-venoms for medical emergencies. MGs have worked with the local VDCs to financially contribute to making latrines for the poorest households, leading to enhanced sanitation in the village, better privacy for the women, and less nuisance due to open defecation in the village. On the program front the FCHV-CCs been found effective in providing support to FCHVs on their activities such as conducting regular MG meetings, providing support in the immunization sessions, and active involvement on Vitamin A, deworming, and polio campaigns. In addition they established a cost recovery scheme to replenish essential drugs and developed a way to use funds generated or raised in savings and credit group for emergency health care. Likewise, the *dalit* participation in the MG meetings was also found to increase recently due to the campaign. Similarly, campaigns and advocacy led by the FCHV-CC has also been found to be very effective in increasing the *dalit's* participation in health related activities and MG meetings.

A Local Resource Person (LRP), an additional link and volunteer position to coordinate and support FCHVs and Mother's Groups, was planned only for Dadeldhura district but has been scaled up to include Kanchanpur and Doti districts. The LRP is an FCHV, selected by a team of local MOH staff, CSP staff, and FCHVs. The LRP is the most active, knowledgeable, and respected FCHV in a VDC. This strategy emerged from difficulties faced by the MOH, CSP, and local NGO partners as they were unable to move to the periphery because of the security situation. The LRP acts as the central contact between the MOH health facilities and supplies of medicines, a hub for communication between the MOH, FCHVs, CSP and local NGO partners, and a collector of reports from the FCHV to be forwarded to the local health facility. Although no monitoring measures were planned to assess the success of this approach, it appears that the system works. The focus group discussion with the FCHVs showed a satisfaction with this arrangement. An indirect benefit is quoted as, "because of LRPs we (FCHVs) have more regular monthly meetings than before and the FCHVs community mobilization has improved as the new FCHVs get support from the LRP."

A suggested way to proceed with this would be for project dialogues with HFMC and VDC to lend support to the LRP in their areas to obtain their sanction for the role of the LRP in their community and facility. LRP is a concept that should be actively considered to be augmented in the other four districts but especially in Bajhang, where distances make interaction between health facilities and the communities more difficult.

The largest short-term **community mobilization event** is the national Vitamin A and De-worming Campaign Day. It is led by the MOH and promoted by national and local media. The VDCs, HFMC, MGs, local NGOs, CSP team, and FCHVs all participate actively in this campaign.

A large scale community mobilization is taking place throughout the project through the *DABI* groups. There are 68 DABI groups in the project area, wherein the 'claiming of the citizens' rights" is promoted. The celebrated cause for *DABI* is the *'Chaupadi'* movement. Initially conceptualized to be a forum for the *dalits,* especially women and

children, *DABI* sees now a more diverse group of participants cutting across caste, gender and community location. *DABI* activities go beyond the issue of *'Chaupadi'* to issues of women and child rights, alcohol consumption in the community, trafficking of women, demanding facilities of the municipality in their area like drinking water provision, call for increased government funding and attention to women and children issues.

Community Mobilization also takes place through the School Health Initiatives in Dadeldhura district. School children are actively taking an interest in the problems facing them (please see new approach page 30) and have initiated actions to specific situations.

*Suggestions*

Mother's Groups are well formed in Kanchanpur. The other 3 districts are in different stages of MG formation. This activity can be quickly scaled up. Though there has been a very good participation of *dalits* so far, this can be further improved. CSP has taken note of this and has proposed the following measures: Caste is seen as a barrier in the MGs. Therefore, in communities where there are many *dalits,* forming distinct *dalit* MGs is a possibility. In communities where *dalits* are a minority, having FCHVs initiate conversations with *dalits* about joining the existing MG is another option which needs to be tried. If that is not seen to be a viable solution then start smaller *dalit* MGs in the community.

*Dabi groups* need further evaluation and documentation of results, as planned by CSP during their overall evaluation of the RBA approach for the *dalits* by an external consultant later in the project. Their success needs to be replicated. Besides scaling up, sustainability should also be addressed with the *dabi* groups. CSP has proposed to strengthen the local NGO through the organizational assessment plan.

Bajhang has faced the toughest challenges due to poor infrastructure of roads, difficult hilly terrain, and getting cutoff during the rainy and cold seasons. There have also been problems in recruiting a suitable Direct Health Supervisor candidate for Bajhang. Taking the above into account, CSP needs to put more emphasis and time into projects in Bajhang so that viable options such as the LRP be scaled up and the participation of local NGOs, MGs and DABI can be increased.

*d.b Communication for Behavior Change*

The CS Project has targeted behavior change in Government health workers, village communities, HFMC and other community level health activities. Although the project has been implementing BCC activities throughout the life of this project and building on activities from the previous CS Project in Kanchanpur, it was decided to pull together these activities into a cohesive strategy. A six days training was provided by an AED consultant to 14 project staff aiming: (i) to increase the skill to understand the concept, scope and application of BCC in CS project (ii) to prepare the draft of the BCC strategy

paper (Attachment H) The Regional Advisory Committee had advised CSP to first formulate a comprehensive BCC strategy along with MOH and other partners and pilot it in Kanchanpur and then scale up to the other districts. The current BCC strategy is being field tested in Kanchanpur district and after the feedback to the RAC presentation it will be scaled up in the remaining 3 districts in the project staring June 2006.

Project staff provides one-on-one counseling and coaching on interpersonal skills to Ministry of Health functionaries in an attempt to improve the way they interact with patients who visit health facilities. In addition, health functionaries participate in the training of community volunteers and in outreach activities in the communities. Having served as trainers and because of interactions with community members outside health facilities, these functionaries are expected to provide better care to patients who are referred by volunteers and to others who visit their facilities.

During the MTE field visits, the MTE team (in consultation with local health facility staff including AHW, ANM. MCHW) observed that the HWs were working as per the IMCI protocol and following the steps of counseling with considerable finesse. Quality of health service (which included one on one counseling to the patient) being provided by the staff has improved particularly in managing diarrhea and pneumonia cases. The staff reported CB- IMCI training was the main factor that contributed to the improvement.

MTE focus group discussions with FCHVs showed that they were of the view that with implementation of CB-IMCI training their skill in giving health education (particularly in counseling mothers about mother and child health) has improved. Further, mothers' attendance in MG group session has also been found increased and the regularity of the meeting has also improved.

As a large proportion of child care falls as a responsibility of the elder child in the home (baseline survey 18%), CSP is working with Doti and Dadeldhura education department in the schools to raise awareness of using the child to child approach. The school systems organizes talks, quizzes and activities built around enhancing awareness of children towards the rights of the child *vis-à-vis* health provision and health delivery.

Regarding BCC materials, the CSP uses Ministry of Health documents to develop training and education materials. Many of the resulting printed materials, although consistent with Ministry's recommendations, are primarily directed at a literate audience. During the MTE it was noticed that in some communities, some members were found having difficulties to understand the message from formal text as they generally speak a somewhat different local dialect. The CSP should explore the possibilities of incorporating local dialects into training facilitation and/or educational materials.

Project BCC indicators are being measured at different levels. For Mother's Group, the KPC/Rapid Catch Indicators for EBF, immunization, danger signs in children and seeking early health care once the danger signs are identified. For the FCHVS, indicators include the counseling of mothers for ANC/PNC and child health. For the

HW, indicators for the counseling of mothers for ANC/PNC including safe home delivery kit and child health interventions like EBF, Immunization, danger signs of pneumonia/diarrhea and seeking early treatment are being monitored.

Some indicators are being monitored through the monthly or quarterly report, for example, the regularity of MGs meeting. Some indicators are designed to be tested six monthly or annually through the LQAS and some of the indicators will be evaluated only during the final evaluation. The measurements are appropriate and sensitive to the context. The data from the monitoring of the women groups is used by the district partners including the MOH, local NGOs, FCHVs, FCHV-CC in Kanchanpur and MG representatives and also the regional advisory committee. Findings from the data are shared and if required refinements are made or more emphasis is given to an area which is perceived to be neglected. Annually the findings are shared at a wider forum including the national level, local USAID mission, CARE USA and USAID. Inputs from these agencies are used to strengthen the project.

### *d.c Capacity Building Approach*

*c.i. Strengthening the PVO Organization*

In addition to attending formal training events and workshops in the project area, CARE CS Program Manager, Ram Sharan Pyakurel and Amir Khati of Regional Health Directorate of Far Western Region, participated in the 10th annual CS meeting from the 18th to the 22nd of April, 2005 in Malawi. Training Specialist accompanied with CARE RBA core team attended RBA training in India from 15-25th December 2004 and Research Monitoring and Documentation Specialist had participated EPI-INFO regional workshop at Uganda from 18-22nd April 2004. A direct influence of this visit was the support CSP got at the regional level for supportive supervision. Also a regional workshop was held to explore the possibility of incorporating the community score card method in the region.

The CS project has built a capacity to deliver and track healthcare services at the community level, among health facilities, partner NGO, and CARE staff. The strongest capacity building efforts at the community level are from the formation of the FCHV-CC, *dabi* group, based in Kanchanpur, and the strengthening of the FCHVs and MGs. The Ministry of Health actively participate in training activities, and work with the CARE CSP staff and NGO partners to assist in community mobilization, monitoring, and other project related activities.

CARE is working closely with the Logistic Management Division (LDM) at the central level as well as DHOs and HFMCs to expand the CDP in the remaining project districts.

*c.ii. Strengthening the Local Partner Organization*

CSP is trying to improve the organizational capacity of the local partners, CBOs and NGOs, that CSP is working with. Major local partners of CSP are NGOs, Female

Community Health Volunteer Coordination Committee (FCHV-CC), District Public Health Office (DPHO), and Health Facility Management Committee (HFMC). These local partners have received support from project to improve their organizational capacities. Major accomplishment observed include the: a) development of partner selection guidelines to select local partners, b) conducting program orientation for partners(e.g. CSP introduction, CARE partnership strategy including CSP, rights based approach in CSP), c) conducting of capacity building training for partner staff (pre-service-training, CB-IMCI, RBA, LQAS, evaluation and monitoring workshop), d) on-site guidance and support for partner by CSP staff, e) regular interaction during monthly coordination meetings and preparation of a joint work plan, f) representation of CSP partners in district level project advisory committee (PAC), reproductive health coordination committee (RHCC) and district health management committee (DHMC) meetings, g) development of different operational tools, guidelines, and materials to partner staff (e.g., tool-kit for field workers, supervision check list, FCHV-CC capacity assessment tool, proposal development guidelines, child right and school health program).

*Local NGO partners*

The project has partnered with seven local NGOs, two in each new project district where one of the NGO partners is from *dalit* member-based organization. But in Kanchanpur district, the project is also partnering with FCHV-CC to implement community level activities and with one *dalit* organization to implement the *dabi* rights-based initiatives program. These NGOs have diverse capacities in community mobilization and are contributing to the cross-education between project partners. The partner NGOs are well acquainted with grassroots work and have substantial experience in community mobilization, especially to work on *dalit* inclusion issues. The CS project has a goal to reach the *dalit* community and has committed 30% of their resources and time to the project.

*Capacity Building with Local Partners*

The goals of the capacity building are to

- Develop different operational tools, guidelines, and to orient partners and CARE staff through tools such as a tool-kit for field workers, field monitoring checklist, FCHV-CC capacity assessment tools, different concept note such as FCHV-CC organizational development, local resource mobilization, proposal development guidelines, effective group meeting guidelines, *dabi* advocacy center implementation guideline, *dalit* focus program, multi-sectoral approach in CSP, intra-care project integration tools/experiences, child right and school health program.
- Conducted program orientation for partners (e.g. CSP introduction, CARE partnership strategy including CSP, RBA in CSP, tools and guidelines as given above).

- Conducted capacity building training for partner staff (pre-service training, CB-IMCI, RBA, LQAS, monitoring and evaluation workshops)
- Provide on-site guidance by CSP staff to partner staff.
- Conducted regular interactions in monthly coordination meetings and prepare a joint work plan.
- Represent CSP partners in PAC, RHCC, and DHMC.
- Organize exposure visits with FCHVs in Kanchanpur to learn about their experiences.

The roles and responsibilities of each partner organization have been clearly defined in the CSP partnership strategy. Different tools and guidelines that have been prepared by the project help to clarify more about their roles at the task-level. The CBOs strengthened by the project (e.g. Advocacy Centers and FCHV-CC) are contributing to sensitize communities about MOH health services and quality, along with the basic health rights and human rights. They have started advocacy on different local social issues to:

- Regular and good quality outreach and immunization clinics.
- Regulate birth registration and to reduce delay penalty charge.
- Stop the practice of '*Chaupadi'* (i.e. un-touching tradition during menstruation and delivery period) which forces women to live in cattle shed during this period.
- Increase *dalit's* and women's representation in local decision making forums (e.g. FCHVs, MGs, HFMCs).
- Stop the production and sale of alcohol in the community.
- Protest against domestic violence toward women and girls (e.g. girl trafficking and early marriage).
- Increase sensitivity to caste-based discrimination.

CSP conducted an organizational capacity assessment of the partner NGOs and has suggested the development of an organizational development plan based on the finding and to regularize the process. The outcome of the assessment varies between different partners. These findings highlight the following points:

<u>The strengths</u>

- All partner NGOs and CBOs were found to be sensitive to the development agenda.
- All partners have a gender policy in place
- All partners have received some capacity building trainings from different donors
- There is a good commitment to transparency.
- All partners are members of an NGO federation and affiliated to the social welfare council

<u>The areas of improvement</u>

- Most project partners are weak in internal resource mobilization.
- The financial systems can be made more transparent and the internal gender related policies can be improved.

Three indicators reflecting CSP's capacity building of partners was also assessed during MTE. The results are given below.

- All 7 partner NGOs have developed an organizational development plan based on the finding of capacity assessment, whereas 11 out of 20 FCHV-CCs completed assessment and developed OD plan to date, rest are in process to develop.

- All 7 partner NGOs have their resource mobilization policy, but the assessment has suggested re-visiting it and updating as per the present context and it's demand. It's a regular process; accordingly, it has been planned to re-visit it, conduct resource mapping and to develop a strategic plan for both external and internal financial resource generation.

- All 7 partner NGOs have developed different operational policies that includes financial, administration, communication, but yet to develop a comprehensive programming policies (planning and monitoring), it has been suggested during organizational capacity assessment and is planned accordingly for this FY.

CSP's decision to work with NGOs is beneficial, especially when using the rights-based approach (RBA) for the *dalits.* The CSP staff plans to have the RBA in the project area evaluated by an independent consultant should also include the work that the NGOs have done with the *dalits.* CSP needs to work with the NGOs/CBOs on their organizational development plan and help the participatory process so that those recommendations are implemented. The concern of the NGOs/CBOs regarding strengthening their capacities to look/solicit/link to funding should be taken as an important step for sustainability beyond the life of the project

*c.iii and c.iv. Health Facilities strengthening and Health Worker performance*

CSP is strengthening the health facilities through a five point approach:

1. Improving the quality of services provided.
2. Making good quality, essential medicines available and accessible to all members of the community at an affordable cost (only applicable to Kanchanpur)
3. Increase ownership and support of the health facility by the community, through MGs, HFMCs and the VDC. For example, the VDCs support the health facility in different ways including the funding for essential medicine and support for the FCHVS.
4. Improve the reliability and frequency of reporting and level of communication between the FCHVs, HF, District Health Office, Regional Health Office, and National Health Programs. For example, communicating the lack of IFA at the grass-root to the regional and national MOH officials
5. Increasing the capacity of local NGOs and work with other Health/Development plans to channel resources into the community. For example, work with the Micro-nutrition International and the Nepal Family Health Program.

The quality level in the HFs is improving through other means, such as, not only by providing quality CB-IMCI training to the HW and other health staff but through follow-up visits in the field. CSP and MOH partners have developed a system of supportive supervisory visit with use of a supervisory check list while visiting any health facility/health worker in the field. Also the supportive supervision has been extended to include the FCHVs in the area using a different checklist.

The MTE findings show that the system of supervision has been institutionalized at 100% of the HW in the project area, except Bajhang which was 60%. Almost all FCHVs reported a supervisory visit by their supervisor, except in Doti which had a 58% visit rate in the last quarter. This system of supportive supervision helps to identify gaps that might exist in training, skills learned, communication for behavior change, supervision, medicine supply, and communication of administrative notices. During the FGDs the FCHVs have noted that the supervision has helped them fill up their medicine supply on the spot or after a few days and that learning of skills in the village, helps boost their confidence and increase their stature in the community. All staff at the health facilities received supportive supervisory visit in the last quarter (Table 3) except Bajhang. Bajhang showed that only 60% of the staff received these visits. This may be accounted for due to the distance to the health facilities is challenging and infrastructure is poor. The institutionalization of the supervisory visits in the project is a remarkable finding and probably explains to a large extent the improvement that has been made by the project.

In order to strengthen capacity for the delivery of health services, the project supplements training events with review meetings and supportive supervision. Trainees are encouraged to report the problems they face in their daily work during supervisory visits and they receive support from their superiors to solve problems. The project has developed two checklists: one for health facility staff (AHW, ANM, HA) and another for community level health workers, MCHW, VHW and FCHV, with input from the Ministry of Health. These checklists help supervisors to remember key issues when they observe project activities in health facilities and in the communities.

The MTE evaluations see the role of supportive supervision to be of importance as there are still some gaps identified in the knowledge of FCHVs. For example, they did not perform well in identifying two signs of dehydration in children (65% for the districts of Doti, Dadeldhura and Bajhang combined; Table 2).

Community Drug Program (CDP) being implemented by Health Facility Management Committee in all health facilities has been successfully employed in Kanchanpur. With the implementation of the CDP, essential drugs are available throughout the year at the health facility level area and the number of patients visiting health facilities has increased. Likewise, the funds generated by selling medicines in each health facility has ranged from Rs 25,000.00 to 100,000.00. (Appx. USD 350-1450). The community drug program guarantees essential medicine availability to all regardless of purchasing power through the use of a sliding scale or ‘poor free’ policies.

*c. v. Training*

Project partners have conducted several training events during the first half of the project for staff members from CARE; partner NGOs, Ministry of Health, and community-based volunteers. The project training tables are presented in Attachment G. The training workshops included:

A) Training of the MGs and the FCHVs for strengthening group cohesion and support for LRPs (Attachment G: Table B)
B) Training of the HWs and FCHVs on both clinical IMCI and CB-IMCI (G: Table A)
C) Training of partner and CSP staff on a range of issues, the list of which is given below (Attachment G: Table C)
    - Pre- service training
    - Right Based Approach and Advocacy Training
    - Performance Management Training
    - BCC Workshop
    - CSP all staff meeting
    - FGD on Right Based Approach
    - LQAS Training
    - ISP Workshop
    - HMIS training by GTZ
    - PD Hearth Orientation
    - Do No Harm or Spoil Workshop
    - Public Rights and Advocacy Training

*a. Sustainability Strategy*

With technical support from CSTS and encouragement from the local USAID mission CSP is committed to and is working with the CSSA framework to assess the project's sustainability. This project aims to promote long lasting improvements in child health throughout the project districts through positive changes in the health practices of beneficiaries and continued access to information, services, and supplies. To strengthen the managerial and technical capacity of the governmental and NGO partners, community-based volunteers are important. It is also critical to find ways to utilize community for sustainability. An exit plan has been developed for the Kanchanpur district and is in the process of implementation. Two out of the 19 VDCs were already handed over to HFOMC and five are in the process of being handed over by the first quarter of 2006. The project is in the process to develop a disengaging plan within the sustainability framework looking into three dimensions that include: a) health and health services, b) organization, and c) community and social ecology.

The CSP works with different partners at local level that are broadly categorized into four capacities: a) local NGOs, b) Community-based Organization (CBOs), c) District Public Health Office (DPHO), and d) district line agencies. However, the areas and types of partnerships vary. The project provides training and onsite guidance for local NGOs to enhance their health program management and institutional strength. With

this support, the local NGOs contribute to enhance service quality at the community level. The CBOs (e.g. MGs, *Dabi* Centers, and *Dalit* Pressure Group) meet regularly, participate health session, and have critical discussion on the existing quality of health services and advocacy activities at community level. The NGOs provides onsite support for smooth operation of HFOMC, whereas the major role of the health facility operational management committee (HFOMC) includes planning, implementation, and monitoring of health services. The FCHV-CC contributes to improving the quality of FCHV services, providing supportive monitoring at community level, and networking at different levels to influence policy makers for FCHV capacity building opportunities. The project coordinates with the government agencies in the districts and seeks complementary support to enhance health outcomes through different approaches. The DPHO with its hierarchal structure provides health services at the community level. The project contributes to sustain project inputs through the involvement of all segments of the community in health program by enhancing their capacities in the respective areas that ultimately contribute to program sustainability.

Program Management

*1. Planning*

The project is implemented in four districts. All the project districts' activities are coordinated by the regional CARE sub-office based in Doti. A CSP regional team with three specialists is coordinated by a program manager (PM) and includes a Research Monitoring and Documentation Specialist, Training Specialist, and Partnership and Advocacy Specialist. Each district team is coordinated by the CARE CSP District Health Coordinator (DHC); each district is divided into 4 to 6 field areas depending upon the population and terrain. Each field area is supported by one of 20 Health Supervisors: Bajhang has 4, Doti has 6, Dadeldhura has 4 and Kanchanpur has 5. In addition, all the project districts have one Assistant Institutional Capacity Building Office (AICBO) and Logistic Assistant (LA).

At the district level a monthly meeting is conducted to review management issues and program progress. The meeting is attended by the entire project and partner staff involved in the project activities. Likewise, at the regional level a quarterly meeting is held to review the progress. The participants of the regional meetings include four District Health Coordinators (one from each district), a Program Manager, and three regional level Program Specialists.

In the three hill districts, the community level CS activities are implemented through six partner organizations (two for each district). Among the two-partner organizations involved in CS activities, one is from *dalit*. In case of Kanchanpur, the project activities have been implemented through FCHV-CC. The district team and the partner organization work closely with the Female Community Health Volunteers (FCHVs), Mother's Group, Health Facility Operation and Management Committee (HFOMC), and local health facility staff.

In all project districts there are district level project advisory committees (PACs). PACs are intended to enhance the overall program with valuable guidance and support. There is also a regional level PAC formed to support CS activities in the region. Both district and regional level PACs meet bi-annually. Project management issues are discussed in these committees. However, some supply and staffing issues can only be addressed at the national level. Project management is likely to improve if a national advisory group is constituted to review project progress and provide support.

Other than the district level PAC, two other advisory committees meet every two months in all project districts. These are the Reproductive Health Committee and the Quality Control Committee.

Planning has been a continuous ongoing process and involves all relevant players and partners at different stages of project strategizing and implementation. At the DIP the MOH at the central, regional, district, and health facility level, USAID local mission, national and local NGO partners were involved. Also FCHVs of Kanchanpur and members of MG of Kanchanpur were involved. For implementation, local players including local CBOs/NGOs, HFMC members, VDC members, school children, school teachers the district education unit, other development program in the area like *Ujyalo* and National Family Health Project members are actively involved. Also involved are very local interested partners like the salt traders. Besides these, the key involvement has always been from the MG, FCHVS, HWs at the health posts and other peripheral health units.

This project is around 35% behind schedule due to the ongoing conflict situation. The activity and point of interruption have been two-fold, both beyond the control of the project. Other concerns include the inability of FCHVs to participate in the CB-IMCI training as many have not yet received the basic FCHV training. As per the talks with the MOH, the MOH is under funded to take over the basic training of the new FCHVs. The CSP does not have dedicated funds for basic training of FCHVs in the budget. The high dropout rate of FCHVs in the hill districts has caused difficulties for the project in selecting and training FCHVs.

Possible solutions which are being worked on include: CSP is actively inviting the earlier trained FCHVs who dropped out due to any reason, to continue to function as FCHVs (as a part of the MTE, CSP interviewed 44 FCHVs who had dropped out to understand the reasons for their drop out and 55% of those who were interviewed expressed a willingness to rejoin as FCHVs); writing sub-proposals to different donors to fund the basic training for FCHVs, so that the CB-IMCI training can be given to them[1].; working with MOH to explore funding for training of FCHVs;

[1] The CARE Nepal CSP XIX has recently received a donation of around USD 40,000 from a CARE USA private donor. This donation will be used to address the training issue.

- The programs objectives are clearly understood by all CSP staff, partners, and the community as the earlier Kanchanpur experience served as an example to follow.
- Most partners and other parties have a copy of the DIP, but due to transfer/migration of staff sometimes these are misplaced and not at hand, for example, the DHO Kanchanpur did not have a copy at hand of the DIP. The CSP staff were asked to provide the DIP copy to the DPHO Kanchanpur and he was provided a copy of the same the next day.
- At all meeting listed above with the project partners and also as a part of MTE, project partners presented the data and interpret it and then discuss the findings to reach a consensus on how to move forward.

*2. CSP Staff Training and Supervision*

As described in Section d.c (Cross-cutting Approaches: Capacity Building Approach) project and partner personnel have participated in a number of training events during the first half of the project. New knowledge and skills are also being monitored and reinforced through review meetings and supportive supervision. Adequate time and other resources are dedicated for staff training.

CSP offices are located in each district and the district coordinator in each district is responsible for CSP staff supervision. Quarterly meetings are carried in each district and experiences, achievements and areas for strengthening are reviewed. The review meeting takes into account the activities that were planned according to the DIP and where the individual staff member is in relation to his/her job description, IOP, annual plan and the DIP.

*3. Human Resources*

Ministry of health staff members at the district office and health posts are frequently transferred. For instance, many Health Facility staff trained with the CB-IMCI strategy were found to be replaced in recent months. This disrupts service relationships with community members and programmatic decision making. Central authorities often overturn staffing decisions made by the chief of the District Health Office. This is a matter that needs attention from a national advisory group.

*4. CSP Staff Management*

All positions have been filled throughout the life of the project, except the post of the District Coordinator at Bajhang, which is the most remote of all districts. Of late the District Coordinator position at Bajhang has also been filled. The project has seen a higher turnover of staff than usual at almost all staffing levels, but replacements have been quickly found. Key personnel policies and procedures are in place, staff has job descriptions. The morale of the staff is high despite the given security concerns in the field.

*5. Financial Management*

The finance person for the project has worked with CARE for the last 18 years dedicated to finance alone. CARE Nepal uses the double entry finance operation system named SCALA at all levels, which is also CARE's universal finance operation system. The Project Manager receives monthly summaries of expenses from the CSP regional office in Doti. Expenses are tracked against budgeted amounts on an ongoing and annual basis.

The overall amounts of USAID funds expended are as to the schedule. The burn rates are along expected lines. The overall project burn rate is 48%, a little less than the project time duration which is 51%. The finance and project people at Katmandu and Doti were aware of this and explained that because of security issues, some training sessions were cancelled and therefore the program budget is under spent. This is likely to catch up once the trainings are rescheduled. All other expense line items are near or in line with expected expenses.

*6. Logistics*

Logistics for the project are running smoothly. Supplies to the field staff and the project are available on time and when required. At times issues of communication by phone and e-mail pose a challenge because of poor infrastructure, remoteness, distances between districts and head quarters, and adverse weather and climate conditions. Vehicles and travel kits are available as needed.

*7. Information Management*

A monitoring system is in place. Female community health workers compile data on the services and share them with project staff.

The project also plans to conduct a survey every six months to monitor progress about changing health knowledge and the practices of caregivers in project districts. The lot quality assurance sampling (LQAS) technique is used to identify 19 households in each field area. Project staff conducts interviews with mothers of children from the ages of 0 to 11 months and 12 to 23 months of age. Then they summarize the survey results, discuss problems, and suggest solutions for each field area especially those which are not meeting the target. The results for each district are shared with the PAC of the district and options to improve are discussed and recommended for implementation. They also combine findings for the field areas to generate results for the entire districts. While this is an excellent system for identifying and solving problems, it is also too detailed and produces information on a very large number of variables. It is difficult for project partners to meaningfully discuss such a long list. Project monitoring can be improved by focusing attention on a short list comprised of one or two indicators for each technical area.

The consultant, during the MTE also assisted key project staff to sort out some of the issues they have faced in administering LQAS monitoring tools.

*9. Technical and Administrative Support*

Several organizations and individual consultants have provided technical assistance to the project. Trainers from the Nepal Pediatric Society (NEPAS) conducted basic and follow-up training on integrated management of childhood illness Dr. Sanjay Sinho, CARE-USA Atlanta, assisted with the project start-up workshop and CARE- USA back up assisted in terms of supporting annual report writing, LQAS refinement and answered technical and administrative questions. CARE-USA also has helped with identification of international workshops for CSP staff, for example the Epi-Info training and has shared technical updates and manuals from time to time.

*10. Mission Collaboration*

CSHGP is placing increased emphasis on coordination with USAID Missions and their bilateral programs for improved in-country complementarily of programming. CARE CSP XIX contributes to the local mission's bilateral efforts in Nepal (can you find USAID Nepal Strategic Objective to quote?).

CARE CSP maintains good coordination with USAID Nepal, with regular updates on the project progress and annual report. In addition, sharing and discussions are done with mission's health personnel on various occasions, when there is any request by the mission, or when CARE has some information to share. Moreover interactions are also held with the mission personnel through telephone, email, and meeting in various forums.

After the several rounds of discussions and joint assessment with local mission and Nepal Family Health Program (which is also funded by USAID local mission) on the need for malaria control activities in Kanchanpur district, CARE Nepal succeeded to obtain some additional funding through NFHP and communities are getting laboratory support which helps in early case detection and treatment, improving the quality of services and strengthening health service delivery mechanism in the district.

CARE- Nepal been also participating in the mission led initiative on the Child Survival Sustainability Framework and shared their experience in working towards sustainability. Some of the CSP approaches of working in partnership with FCHVs, Health facility management Committees, and Mother's Groups have been identified as means to gear the programs towards sustainability. With the technical support of CSTS+, CSP has already provided orientation to its staff (Kanchanpur district) to adapt sustainability framework as a tool to assess project's progress in coming days.

The project sharing of CSP mo*dality* to work in conflict situation has been quite useful for the local mission in reviewing and disseminating successful working mo*dalit*ies.

Implementation of CB-IMCI is one of the major interventions of the MOH. The CSP XIX has made a solid contribution by building the technical capacities of the health facilities in four districts in the remote areas. Particularly the CSP's contributions include:

Capacity building of community level health care providers (HFs, HFMCs, and FCHVs)

- Capacity building of community level health care providers (HFs, HFMCs, and FCHVs)
- Creation of Community ownership through community mobilization, sensitization on their rights to health care, accessing health services and development of Local Resource Persons for future support to the communities
- Improving the quality of health care services in the project districts. The percent of case identifications (ARI and CDD) has increased and service utilization has increased remarkably in the project districts. Kanchanpur has been awarded as the best district in the Far Western Region in terms of achieving the expected health indicators. The other three districts are also picking up in terms of improving the health status.
- Bringing in multi-sectoral development actors closer to the child and maternal health efforts
- Initiated the application of Rights based approach in health care, by adapting the inclusiveness approach, and organizing various activities for the community empowerment.

D. Other Issues Identified by the Evaluation Team

No other issues were identified by the evaluation team

E. Conclusions and Recommendations

The Child Survival project is well planned, draws on the resources of carefully selected partners, and is being competently managed by the CSP team with the help of CARE's Kathmandu and U.S. offices, and the Ministry of Health. Summarized below are project strengths, areas in need of improvement, and recommendations of the evaluation team.

***Project strengths***

*Excellent working relationships*

Many current project team members have worked together for years since phase one of the previous Child Survival Project. They work well with each other and also with staff from partner organizations. They are familiar with the activities with the project and are also capable of managing community interventions and partnership development. Representatives of local non-governmental organizations, district health office, SWC and CARE Katmandu, NGO Partners and beneficiaries, and US offices have appreciated the project staff for their excellent teamwork.

*Promising activities at community level*

Regular meeting of MG as envisaged by the CSP is one of the examples of promising community level activities. Based on the findings of MTE, mothers are meeting regularly in the project districts and serving as a forum for discussion on the matters of health problems and for educating members and mothers in maternal and child health issues. Mothers are encouraged to visit health facilities for preventive health services.

*Good achievement of targets*

The project has already achieved many of the targets that it aimed to attain by the mid-term period. Mothers' knowledge and practices related to diarrhea, pneumonia, and child spacing has increased. So have the knowledge and skills of FCHV and the HWs regards the CB-IMCI objectives.

*Successful Community Drug Program (CDP)*

The CDP in the Kanchanpur district has been functioning very well. Essential drugs in the local health facilities are now available throughout the year and the fund generated by selling drugs ranges from Rs. 25,000.00 to Rs.100,000.00 (Appx. USD 350-1450). In addition, the number of patients at the health facilities has also increased after implementation of CDP program.

*Interlinking the community based structures*

The HFMC has been invigorated and the VDCs have been approached to take greater interested in the function of the HFs. MGs nominate the FCHVs, and then the FCHVs are trained by the MOH at the local level. CSP then upgrades the training skills of the FCHVs on IMCI. FCHVs in Kanchanpur have come together to form a CBO the FCHV-CC. The FCHVs in some places are also selecting the LRP to communicate between them and the local health systems. The HFMCs support the FCHVs in different ways, the common ways celebrating the annual FCHV day and providing refreshments during the Vitamin A campaign day.

*Incorporating RBA*

Through the *dalit* MGs and through the *dabi* movement, women's empowerment is taking a whole new meaning in the rural areas of Nepal. *Dabi* groups have successfully protested against the *'chaupadi'* tradition and now actively participate in HFMCs and other social action initiatives.

*Malaria, PD Hearth and MNC*

These have been local successes in Kanchanpur. MNC and PD Hearth may be scaled up to some extent in the remaining 3 districts.

***Areas for Improvement and Recommendations***

1. Partner NGOs and FCHV-CC have limited skills in conducting organizational assessments (OAs) and to develop and implement organizational plans.

- Capacity Building training for partners NGOs and FCHV-CC to enhance their skill on organizational assessment and to implement organizational plan.

2. The level of participation of *Dalit* and marginalized people has improved significantly but can still be improved in MG activities.
    - FCHVs should be encouraged to target the marginalized clusters through mobile MG meetings. Also where the proportion of *dalits* is high, *dalit* MG can be formed. If the proportion is low, extra efforts should go into incorporating them into existing MGs to increase the level of participation of *dalits* in MG activities. Skill and sensitivity training to NGO and FCHV-CC need to be imparted to ensure meaningful participation of *dalit* and marginalized.

3. The existing efforts appear to be insufficient in order to link NGO and FCHV-CC with other partners in tapping resources.
    - Strengthen district level NGO and FCHV-CC networks and link them with other stakeholders to access more resources.

4. Insufficient documentation and dissemination of best practices and achievements (for example, *Dabi* and CDP).
    - Document best practices and transfer communicate the information to other CSP districts. Alternatively, as the project runs against time, cross-visits by grass-root level players from the three districts to Kanchanpur or *visa-versa* would achieve the same results.

5. Ministry of Health staff members at the district office and health posts are frequently transferred. This disrupts service relationships with community members, hampers programmatic decision making, and makes regular supervision difficult. Health facilities and community based health workers face shortages of some medicine and other commodities, such as Oral Rehydration Solution packets, and Vitamin A to administer to women after delivery. District-level committees meet regularly to discuss project management issues. However, some supply and staffing issues can only be addressed at the national level.
    - Form a national advisory group to review project progress and provide support. Include representatives from the Ministry of Health, the divisions of Child Health and Family Health, CARE, both Katmandu and Doti offices, and regional director of Far Western Health Directorate. Organize meeting of the advisory group every six months, shortly after each lot quality assessment. Alternatively, CARE-Nepal could form a representative forum with other CS NGOs and donors who face similar issues at the national level. The MOH, Child Health Division and Family Health unit could be the chair and this forum thereby providing a space to share common concerns that are faced by the child survival projects in Nepal.

6. LQAS surveys: It is difficult for project partners to meaningfully discuss the long list of indicators that is generated by the assessments.
    - Use a short list of indicators in a discussion with project partners. Other than this, CARE staff should identify one or two indicators within each technical area in consultation with the partners. The advisory groups should review these priority items during their meetings. They should give special attention to indicators where there has been slow progress during the first half of the project. The minimum that need to be gathered would be the rapid catch indicators and other indicators committed to in the DIP.

7. Project staffs have used Ministry of Health materials to develop training and education materials. They have ensured that the text of manuals and guides used to train health workers and flipcharts and other aids used to educate community members is consistent with nationally recommended documents. However, some community members and FCHVs find it difficult to understand as the local dialect is somewhat different.
    - Project staff should explore the possibility of adapting local dialect in the training facilitation and educational materials (as feasible). During CSP BCC strategy review, this would be a good forum to discuss this finding.

8. The LQAS indicator for completed immunization shows a precipitous drop in the 3 districts of Doti, Dadeldhura and Bajhang.
    - Secondary or other sources of data need to be studied to verify if this is a correct finding or an error. In case other sources of data verify this sharp drop, reasons for this drop must be ascertained and corrective measures need to be taken. In case of an error, special attention needs to be mentioned in the annual report.

9. The local NGOs and CSP staff are at times duplicating work. This is most likely due to security concerns that the organizations face and therefore are 'squeezed in' the same geographical area.

    - The PM should review the situation and if needed change TORs
      MOU based on individual contracts with local partner NGOs on an individual basis.

## III. The Action Plan for MTE CSP Nepal (2006)

| Recommendation | Action/Activities | Responsibility | Supported by | By when |
|---|---|---|---|---|
| Capacity building of partner NGOs and FCHVs for organizational development with special emphasis on social inclusion (especially for CS program) | 1. Organization development training for NGOs and FCHC-CC<br>2. Assist regular self capacity assessment of the Partners of FCHV-CCs<br>3. Develop capacity of the partners NGOs to sensitize them to include (poor, vulnerable and socially excluded particularly *dalit*) at all level of project implementation.<br>4. Ensure organizational development of strategic plan and implementation of the NGOs and FCHV –CCs that at least 30 % of the membership and beneficiaries should be from the *dalits.* | 1. PAS<br>2. AICBO<br>3. AICBO | AICBO, TS | 1. March 2006-01-16<br>2. Activities 2,3,& 4 should be completed by March 2007. |
| Encourage and ensure FCHVs to target *dalit* and marginalized clusters (Mother's Group) and strengthen Mother's Group capacity to act accordingly. | 1. Expand the membership of MG<br>2. Enroll poor, vulnerable, and socially excluded, particularly *dalit* in MG<br>3. Facilitate to form *dalit* women group<br>4. Explore and expand MG mobile meeting | HS | AICBO | December, 2006 |
| Strengthen district level NGOs | 1. Organize interaction workshop with district level stake-holders<br>2. Facilitate cross learning environment (excursion visit) among stakeholders.<br>3. Building capacity to tap resources. | AICBO | DHC | June 6, 2006 for Kanchanpur and December 6 , 2006 for other districts |
| Document best practices and transfer the learning to other CSP districts | 1. Identify the best practices and document the process required for replication.<br>2. Dissemination of the findings<br>3. Replicates the best practices | PM | PC-H/CHS/RM&DS | Identification of best practices by March 2006 Kanchanpur documents 3 best practices. Other districts do 1 each. |
| Clarify roles and responsibility between NGO partners and CSP. | 1. Assessment of existing CSP partnership with NGOs<br>2. Review terms of reference (TOR)/ memorandum of understanding (MOU)<br>3. Modify and finalize TOR/MOU as per review recommendation | PM | PAS | February 2006 |
| LQAS: Use a short list of indicators for discussion with project partners | 1. Explore the possibilities of few representatives indicators by the project staff and use to monitor CS activities bi-annually<br>2. Enhance the capacity of staff to apply and practice the LQAS in CS project | RM&DS | CHS,PM, TS | February 2006 |

| | | | | |
|---|---|---|---|---|
| A national advisory group needs to be formed to review the project performance and advocacy at the national level for project successes Alternatively CARE joins or forms an already functional group with other NGOs and donors for the same vision | 1. Explore the possibility that CB-IMCI working group can work as PAC for CSP.<br>2. Explore if there are other fora for advocacy regarding common issues in the CS world in Nepal.<br>3. Explore joining or formation of a new forum with other NGOs working in child survival or MCH facing similar issues. | PC-H | PM/CHS | December 2006 |
| Incorporate local dialect in project training and educational materials. | 1. Explore the possibilities of adapting training and education materials and pilot the material.<br>2. All trainings to use local dialects, explore possibility of using training material in local dialect | TS | DHS | April, '06 |
| Thoroughly Investigate if the drop in immunization rate is correct as seen in the LQAS findings and thoroughly investigate the cause if any | 1. Review secondary data for the concerned 3 districts on immunization<br>2. Identify supervisory areas doing poorly<br>3. Identify if any reasons for this drop out<br>4. Discuss with the district and regional advisory committee on how to improve the immunization rates | RM&DS PM | DHC/HS | August. '06 |

F. Results Highlight

*Child's Health Rights*

Dadeldhura district, in the far western region of Nepal, is working on the child to child approach for child rights. The project works in two Village Development Committees (VDCs) out of the 20 VDCs in the district. The children involved in the program chose to focus on the issue of birth registration.

This issue was taken up by school children as they realized that enrolling in school required a birth registration certificate and many families do not have their child's birth registered. The school children raised awareness in the community about birth registration, through songs, plays, and a door to door encouragement campaign. However, the civil system was punishing parents if they were registering the births late. According to government rules, birth registration is compulsory but due to illiteracy and poor understanding of the issue, actual birth registration is extremely low. Birth registration is free for up to 35 days after birth and costs 50 Nepalese Rupees (Rs), or 0.75 USD, after that period. This is a prohibitive fee for families earning less than a dollar a day.

The children came together to present their case to the VDC birth registration clerk and told him about their efforts to increase birth registration. Through these negotiations the late fee for birth registration was reduced from Rs 50 to a more affordable Rs 15 (approximately USD 0.20). This situation improved the impetus of the birth registration drive of the children. The overall birth registration improved from less than 10% to approximately 60% for the VDC. This entire experience has tremendous potential for vital statistics, early childhood mortality, school enrollment, and other issues like land transactions and citizenship claims.

**ATTACHMENT A. Baseline Information from Detailed Implementation Plan**

Important information about the project is summarized below. There have been no substantial changes after the detailed implementation plan was approved, except for the beneficiaries numbers reported in Attachment G.

Among all countries in the world, Nepal ranks 51st in country development, based on the indicator of Under-Five Mortality Rate (U5MR.) (UNICEF 2002). As a result, Nepalese children carry the burden of disease and suffering that limits their capacity to realize their full genetic potential. In response to this situation, CARE International is submitting the following four-year Child Survival Program Proposal for the Far Western Region (FWR) of Nepal. This proposal is submitted under the USAID/GH/HIDN/CSHGP new Expanded Impact Category (EIC) based on the Community-based Integrated Management of Childhood Illnesses[1] (CB-IMCI) framework. CARE is requesting $2,500,000 from USAID, complemented by $833,370 provided by other sources within CARE. The total budget for the four-year period October 1, 2003 to September 30, 2007 is $3,333,370

Problem Statement: According to UNICEF, Nepal is ranked 51st among developing countries -- several Sub-Saharan countries such as Ghana (49th) and Gabon (54th) were ranked at a similar level (UNICEF 2002). The under-five mortality rate in the FWR of Nepal has averaged 149.2 over the past ten years compared to the national average of 91.2 (DHS 2001). Four proposed Child Survival program districts are among the least developed in Nepal[2]. The remoteness of the region, lack of infrastructure, and low levels of female literacy are obstacles to families' use of available health care services. Female Community Health Volunteers (FCHV), the pillar of this proposal, has been shown to be effective agents of behavior change in Nepal.[3]

Target Region and Population: The proposed Child Survival program will work in 4 of the 9 districts in the FWR of Nepal. The FWR is a remote region of the country. Two of the proposed districts, Doti (the Regional MOH HQ), Dadeldhura are hill districts with an elevation of 1,900-14,500 feet. Bajhang District is located in the higher elevation Mountain districts while Kanchanpur, the site of CARE Nepal's present CSXV project, is located in Nepal's *Terai* (lowland) area. The program will cover all of the Doti, Dadeldhura, Bajhang and Kanchanpur Districts (Map Annex 6.1). The target population includes 146,514 children under the age of five and 60,465 pregnant and lactating women, for a total target population of 931,054.

The FWR was chosen due to a high level of unmet needs with little external support in this region. CARE Nepal is committed to working in the remote development regions of the country. Although they have not targeted any health

[1] MOH in Nepal uses the term CB-IMCI to explain community level IMCI activities. Essentially their understanding of CB- IMCI is the same as global understanding of C-IMCI but they are keen that the term CB-IMCI is always used
[2] Netherlands Development Organization (SNV) 1997
[3] Nepal child survival case study (technical report); BASICS, USAID and MOST

care services to-date, the recent Maoist insurgency activities in this area are likely to have a negative effect on the care-seeking behavior of the population. The selected districts form a natural cluster of accessibility with the present CSXV project in Kanchanpur.

Goal: The proposed program goal aims, "To reduce child and maternal mortality and morbidity" which will be achieved by strengthening community and local NGO and MOH capacities in the Far Western Region of Nepal".

Strategic Approaches:

A. To demonstrate successful and sustainable implementation of CB-IMCI (especially for management of pneumonia and diarrheal disease) through improved quality of care strategies,

B. To strengthen linkages between local government and civil society participants in health care management at the Health Post (HP), Sub Health Post (SHP) and District Health level; The key activities undertaken will include Health facility Management committee (HFMC) strengthening in all four districts and supporting Community Drugs Program (CDP) training in Bajhang

C. Develop a sustainable program implementation model in Kanchanpur through strengthening community support i.e., Female Community Health Volunteer coordinating committee (FCHV-CC), Village Development committee (VDC) / District Development committee (DDC) and linkages with line agencies of His Majesty's Government (HMG)

D. Strengthening of project staff and other stakeholders capacity (especially marginalized communities and women) to operate in existing environment of insurgency in Nepal

E. Evidence-based advocacy to increase support for CB-IMCI by regional and national MOH Child Health Division.

The proposed program for Expanded Impact is focused on the transfer of skills to partners from the moment of CSXIX implementation, as a strategy to reduce CARE Nepal's role as direct implementers. CARE Nepal will build the MOH and local NGO partner's capacities (such as the FCHV-CC's in Kanchanpur). Capacity-building activities will enable various segments of society to achieve effective representation within District and sub-District HFMC's, as forums for increasing local government and civil society participation in health care management. The proposed CSXIX program will coordinate the training and monitoring of CB-IMCI implementation for pneumonia case management and control of diarrheal disease at the District, HP, SHP and community level. These trainings will be conducted with the support of the Nepal Pediatric Society (NEPAS) and the Nepal Technical Assistance Group (NTAG). District health personnel will receive up-to-date training for the provision of services within a quality of care framework. MOH outreach to communities will be strengthened by linkage of HP/SHP staff with communities through the monitoring and supervision of FCHVs.

Program Objectives:

- Objective No.1, Access to Services and Supplies: Families have increased sustainable access to health education, quality health care services, and essential medicines at the community level.
- Objective No.2, Quality of Care: Community level MOH personnel, Female Community Health Volunteers (FCHV), and other service providers practice appropriate case management of pneumonia and diarrhea, and other key IMCI intervention areas.
- Objective No.3, Behavioral Change: Caregivers of children below five years of age practice healthy behaviors and seek medical care from trained sources when needed.
- Objective No.4, Building Local Capacities: Local and community-based institutions and local NGOs are strengthened to support child survival activities on a sustainable basis.

The overall project will be implemented within an implementation framework of supporting CB- IMCI, but the effort spent at the intervention of the project will be as follows:

- Micronutrients (35 % in Doti / Dadeldhura / Bajhang and 25% in Kanchanpur)
- Control of Diarrheal Disease (CDD) (30 % in Doti/Dadeldhur/Bajhang and 25% in Kanchanpur)
- Pneumonia Case Management (PCM) (35% in Doti/Dadeldhura/Bajhang and 25% in Kanchanpur)
- Maternal and Newborn Health (MNH) (25% in Kanchanpur from project resources and from complementary resources elsewhere)
- Malaria (from complementary resources in Kanchanpur)

The Baseline also demonstrated minimal awareness about HIV/AIDS and ways to prevent it among project participants (78.8% of surveyed population had not heard of HIV/AIDS and only 9.5% knew two ways to prevent it). As a result, the project will actively solicit complementary resources to implement HIV/AIDS intervention also.

To achieve project objectives in addition to above-mentioned technical approach the project will concomitantly focus on the following crosscutting strategies to respond to prevailing situations in Nepal:

- Linkages with stakeholders and various agencies of HMG
- Focus on disadvantaged (ethnic or low-caste groups)
- Integration with other CARE projects[4]
- Promotion of community cohesion

[4] In line with the MSP approach

- Focus on gender and child rights

This Detailed Implementation Plan (DIP) has been repeatedly discussed, from the proposal stage to the final draft, with Sheila Lutejans, John Quinley, Dharmpal Raman, and Sita Ram Devkota of USAID/Nepal. The DIP was prepared by CARE Nepal's project team in close collaboration with MOH staff and other stakeholders at district regional and national level. Dr. Sanjay Sinho at CARE headquarters helped document the discussions.

**ATTACHMENT B. Evaluation Team Members and Titles**

The core team leaders of the fieldwork consisted of the following:

- Ram Sharan Pyakurel, Program Manager, CSP, CARE Nepal
- Deepak Poudel, Community Health Specialist, CARE Nepal
- Khrist Roy, Technical Advisor, CARE, Atlanta
- Babu Ram Devkota, Consultant (MTE Team Leader)

The following guided or assisted the core team in conducting the evaluation.

**Kanchanpur:**

- Damber Singh Gurung, DHC, Dadeldhura
- Sita Ram Devkota, USAID, Katmandu, Nepal
- Suresh Pandit, Social Welfare Council, Katmandu Nepal
- Sarita Bhatta, NGO Partner, Dadeldhura, Nepal
- Saver Dahal, Female Community Health Volunteer (FCHV), Kanchanpur, Nepal
- Harisha Pal, Sub-Health Post (SHP) In-Charge, Partner
- Bal Bahadur Mahat, District Health Officer, Kanchanpur, Partner
- Upendra Dhungana, AICBO, Kanchanpur, CARE
- Khem Raj Bhatta, Statistics Assistant, District Health Office, Kanchanpur partner
- Lalu Maya Kandel, CARE, Katmandu
- Shanti Thakali, Health Supervisor, CARE
- Uma Devi, FCHV Dadeldhura
- Khrist Roy, CARE, USA

**Dadeldhura:**

- Indra Adhikari, CSP, CARE
- Rishi Raj Lumchali, NGO Partner
- Lav Raj Timsena, DHC, CSP, CARE
- Hari Lal Dhakal, Health Supervisor, CSP, CARE
- Huma Gurung, AICBO, CSP, CARE
- Kali Pun, Health Supervisor, CSP, CARE
- Aphilal Okheda, NGO Partner
- Anamul Hoque, Representative from District Health Office Doti ( Partner)
- Babu Ram Devkota, Consultant

**Doti**:

- Nanda Bhandari, FCHV
- Nur Prasad Pant, Technical Specialist, HIV/AIDS CARE, Katmandu
- Kushum Shahi, Health Supervisor, CARE, CSP
- Deepak Poudel, Technical Specialist, Community Health CARE, Katmandu

- Rahamat Hussain, AICBO, CARE, CSP
- Kakendra Bhandari, Training Specialist, CARE, CSP
- Bohora, DHO Partner
- Bhagat, DHO Partners
- Tirtha Shrestha, Logistic Assistant, CARE, CSP

**Bajhang**

- Ram Sharan Pyakurel, CSP, CARE
- Shiva Datta Bhatta Regional Health Directorate, Partner
- Bijay Bharati, CSP, CARE
- Shashi Shah, CSP, CARE
- Ram Narayan Shah, CSP, CARE
- Phutu Shrepa, CSP, CARE
- Nara Bahadur, BK, CSP, CARE
- Krishna Pal Bohora, CSP, CARE
- Dil Bahadur Dhant, CSP, CARE
- Dan Bahadur Karki, CSP, CARE
- Bhanu Bhakta Joshi, DHO/Partner
- Ganga Joshi, DHO/Partner
- Indra Prasad Poudel, DHO/Partner
- Dharma Biswakarma, NGO/Partner
- Laxmi Oli, FCHV

## ATTACHMENT C: Evaluation Assessment Methodology

The MTE was conducted in a very participative manner in all the stages, which include the planning stage, the workshop and analysis of data stage and finally the sharing and presentation of MTE findings.

Stage 1: The planning stage: the steps taken were:

a) Sharing of resource material between the consultant, the CARE Nepal CSP team and the backstop at CARE USA in Atlanta. Example of material shared included the MTE guidelines from USAID, the DIP of the project and the annual reports of the project.
b) Through constant e-mail and phone calls the methodology to conduct the MTE was outlined. It was agreed that data from LQAS will be used as a part of the MTE. It was also agreed that the DIP process indicators given in the log-frame for MTE will be evaluated and that besides these, the MTE will be essentially gathering of qualitative data, its analysis and the bedrock for project recommendations after weighing in information of the LQAS and the log-frame process indicators.
c) Logistics and administrative fine tuning and consensus making like selection of Kanchanpur as the workshop site, number of teams and number of team members in each team and the workshop dates was arrived at.
d) List of key stakeholders for which the tools need to be designed was discussed.
e) List of possible invitees for the workshop and for data collection and analysis was done.
f) List of invitees for the MTE presentation was made.
g) Meeting with USAID Nepal representatives was done to make them aware and take their inputs for MTE. USAID Nepal participated in the Kanchanpur workshop and also asked CSP to verify the reasons for the high drop out rare of FCHVs.

Stage 2: MTE Training Workshop in Kanchanpur (28$^{th}$ and 29$^{th}$ of December 2005)
The activities carried out in the workshop were:

a) Participants in the workshop were very well represented of all key stakeholders and included:

   The MOH represented by the Regional Health Directorate for the Far West Region and related line agencies like the DPHO, the Health Centers and the Health Posts. Participants included were the doctors, nurses, health workers and administrative staff from all levels of the MOH hierarchy. National bodies like the Social Service Council were represented. From the local USAID mission a Program Specialist participated throughout the duration of the workshop. From the community members from mothers group, FCHVs, members of FCHV-CCs, local partner NGOs also participated. CARE Nepal's head quarter, non CSP and CSP representatives participated and so did the regional and local district team members participate.

b) Design and validation of the interview guides was done.
c) Selection and finalization of key informants to interview at different levels, including the village, the district and the regional health office was done.
d) A total of 13 in-depth-interview/FGD, field observation and consultation tools were discussed and finalized with the entire team.
e) Training session was conducted on how to conduct key informant interviews, focus group discussion with small group discussion and role plays were done to gain clarity and confidence.
f) As information on the number of tools, number of sites to be visited and the duration of each interview tool were now available, team sizes were optimized. Care was taken to gender balance the team.
g) A core team was created which consisted of the consultant, the CSP Project Manager, CARE-Nepal representative and CARE-USA backstop person. The job of the team was to oversee the technical aspect of the MTE and to work with the logistics team for the MTE which comprised of the regional and local offices of CSP in order to smoothen the logistic operations. The CORE team member was also the nodal point for each district to advise and decision making regards the safety related of the entire district team or issues to logistic or technical difficulties that could possibly be faced. The phone numbers of all CORE team members were shared with the selected data collectors.
h) The MTE workshop selected team members for each district for data collection. Each district team had a local DHO member and also a local CSP, both were nominated for administrative and logistic reason and did not participate in data collection.
i) The data collection was finished in 5 days (excepting Bajhang which took longer). Data compiling and analysis was done in a participative manner by individual district teams and took between 4-5 days.

Stage 3: Presentation of MTE at Kanchanpur and Kathmandu

Two final presentations were done, incorporating key findings and recommendations from all district. One was done at Kanchanpur to benefit all local partners and DPHO, data was presented by each district. All DPHOs participated in the presentation and noted the findings and recommendations for their district.

For the benefit of national level partners which included the National MOH from the Child Health Division, NGO partners at the national level, donor agencies including the local USAID mission another presentation MTE was done. Findings and recommendations were shared and their inputs noted.

The details of the instruments, groups, and individuals consulted during the fieldwork are presented in the following table:

| Group/Individual | Total # | Remarks |
|---|---|---|
| Mothers Group | 10 groups | |
| FCHV Group | 8 groups | + 3 FCHV CC in K'Pur |
| FCHV Dalit | 12 individuals | |
| FCHV Drop out | 43 individuals | |
| District Health Officer | 4 individuals | |
| Health Facilities (PHCC/HP/SHP) | 12 facilities | |
| Health Facility Operation and Management Committee | 4 groups | |
| VHW/MCHW | 16 individuals | |
| *Dalit*/*DABI* Group | 4 groups | |
| Partner NGOs | 4 organizations | |
| Project Advisory Committee | 2 committees | |
| Municipality Officials (Kanchanpur) | 1 individual | |

## ATTACHMENT D. List of Persons Interviewed and Contacted

### Community

Female community health volunteers, Mother's Group members, FCHV-CC members, executives and staff of partner organizations, members of health facility operation and management committee.

### Ministry of Health:

Dr. Sun Lal Thapa, Child Health Division
Dr. Indra Poudel, DHO, Bajhang
Dr. Lok Raj Paneru, DHO Dadeldhura
Mr. Bal Bahadhur Mahat, Health Administrator Kanchanpur
Dr. Sher Badhur Chand, DHO, Doti
Mr. Shiva Dutta Bhatta, Public Health Officer, Regional Health Director, Far West Region
Health Post and Sub Health Post Supervisors
VHWs and MCHWs

### Social Service Council

Mr. Suresh Pandit

### USAID:

Mr. Sita Ram Devkota, Program Specialist, USAID
Mr. Dharmapal Raman, Program Specialist, USAID
Mr. John Quinly, Health and Child Survival Advisor, USAID

### CARE USA:

Dr. Khrist Roy, CARE, USA

### CARE, Nepal

Ms. Niramala Sharma, Health Sector Coordinator
Mr. Deepak Paudel, Community Health Specialist
Ms. Alaka Pathak, Country Director, CARE Nepal
Dr. Bala Ram Thapa, Assistant Country Program Director
Mr. Krishna Sharam, CARE Nepal
Dr. Karuna Oanta, CARE Nepal
Mr. Ram Sharan Pyakurel, Program Manager, CARE CSP
Mr. Bijaya Bharati, PAS
Mr. Indra Adhikari, AICBO
Mr. Bhandari, DHC – Bajhang, CARE
Mr. Damber Singh Gurung, DHC, Dadeldhura
Mr. Upendra Dhungana,, AICBO, Kanchanpur, CARE
Ms. Shanti Thakali, Health Supervisor, CARE
Mr. Raj Timsena, DHC, CSP, CARE
Mr. Hari Lal Dhakal, Health Supervisor, CSP, CARE
Ms. Huma Gurung, AICBO, CSP, CARE

Ms. Kali Pun, Health Supervisor, CSP, CARE
Mr. Nur Prasad Pant, Technical Specialist - HIV/AIDS CARE, Katmandu
Ms. Kushum Shahi, Health Supervisor, CARE, CSP
Mr. Rahamat Hussain, AICBO, CARE, CSP
Mr. Kakendra Bhandari, Training Specialist, CARE, CSP
Mr.Tirtha Shrestha, Logistic Assistant, CARE, CSP

**ATTACHMENT E. Project Data Sheet**

**Child Survival Grants Program Project Summary**

**CARE Nepal Field Contact Information:**

Tel: Fax
Project Manager: R.Saran

| | |
|---|---|
| **First Name:** | Ram Sharan |
| **Last Name:** | Pyakurel |
| **Address:** | CARE-DOTI (PN-41 CSP II - Bal Bachau in Far West) Regional Office |
| | Silgoun Mathillo Bazaar; Dipayal Silgadhi municipality, Ward #1 |
| **City:** | Doti |
| **State/Province:** | Far Western Province |
| **Zip/Postal Code:** | - |
| **Country** | Nepal |
| **Telephone:** | 094-420518 |
| **Fax:** | 944-420519 |
| **E-mail:** | cspdoti@carenepal.org |
| **Project Web Site:** | Nil |

1. **Project Information:**

| | |
|---|---|
| **Project Description:** | The second phase under the Expanded Impact Category for the CS project was implemented in the Kanchanpur district between October 1999 and September 2003. This phase of the project works in three other districts of the Far West province Doti, Dadeldhura, and Bajhang, in addition to Kanchanpur, to contribute to reducing child and maternal health disparities. The project will work within the framework of the IMCI with the main components being Pneumonia Case Management (25% in Kanchanpur and 35% in the other districts), Micronutrients- IFA, Vitamin A, deworming and Iodine Deficiency disorder (25% in Kanhanpur and 35% in the other districts), Control of Diarrheal Diseases (25% in Kanhanpur and 30% in the other districts), and |

| | |
|---|---|
| | Maternal and Newborn Care (25% in Kanchanpur). The CB-IMCI, health system strengthening, quality assurance through PDQ, strengthening of Community Drug program and Behavior Change Communication within BEHAVE framework will be the primary technical strategies of the project. The project will work to strengthen local capacity by working with health facilities, local NGO/CBO's, coordination committees of Female Community Health Volunteers, and enhancing community ownership of health facilities through strengthened Health Facility Management Committees and local government (VDC/DDC) involvement.<br><br>This project will work on cross-cutting strategies such as creating linkages with other HMG and stakeholders agencies, focusing on the disadvantaged (ethnic or low-caste groups), integration with other CARE projects (inline with MSP approach of C-IMCI), promotion of community cohesion (through 'do no harm' training and use of reflect approach), and focus on gender and child rights issues. |
| **Partners:** | Ministry of Health, 2-3 Local NGO/CBO in each district (to be identified; short listed ones are included in section 4) except Kanchanpur where the project will work with FCHV-CC, Local Government structures DDC/VDC, Department of Education in Doti |
| **Project Location:** | Districts of Kanchanpur, Doti, Dadeldhura, and Bajhang. |

**2. Grant Funding Information:**

| | | | |
|---|---|---|---|
| **USAID Funding:(US $)** | 2,500,000 | **PVO match:(US $)** | 833,378 |

**3. Target Beneficiaries:**

| Type | Total |
|---|---|
| **Infants (0-11 months):** | **31,388** |
| **12-23 month old children:** | **30,167** |
| **24-59 month old children:** | **84,949** |
| **0-59 month old children:** | **146,514** |
| **Pregnant and lactating women** | **60,465** |
| **Women age 15-49:** | **227,220** |

| | |
|---|---|
| **II. Total Population** | **931,054** |
| **Estimated Number of Births:** | **34,449** |

*Source: Annual Report, Dept of Health Services, 2002/03*

1. **Beneficiary Residence:**

| Urban/Peri-Urban* % | Rural % |
|---|---|
| 13.85% | 86.15% |

** Based on municipal population*

2. **General Strategies Planned:**

3. **M&E Assessment Strategies:**

4. **Behavior Change & Communication (BCC) Strategies:**

5. **Capacity Building Targets Planned:**

| PVO | Non-Gov't Partners | Other Private Sector | Gov't | Community |
|---|---|---|---|---|
| Field Office<br>HQ<br>CS Project Team | Local NGO/CBO<br>FCHV-CC | Traditional Healers (Dhami/Jhakri ) | Regional and District Health staff<br>Health Facility and out reach staff | FCHV's ; Mother's Group members;<br>School children in Doti |

6. **Interventions:**

| |
|---|
| **Micronutrients (35 % in other district and 25% in Kanchanpur)** |
| *** IMCI Integration |
| *** FCHV Training within IMCI framework |
| *** MOH staff Training within IMCI framework |
| ***Maternal nutrition ( Iron intensification) training in Kanchanpur for MOH/FCHV |
| *** PD/Hearth implementation as special project in Kanchanpur |
| *** Exclusive breast feeding |
| *** Vitamin A/Deworming campaigns for postpartum women and children |
| *** Iodized salt promotion through BCC approaches |
| **Acute Respiratory Infection (35 % in other district and 25% in Kanchanpur)** |
| *** IMCI Integration |

| |
|---|
| *** FCHV Training |
| *** Case Management training for MOH |
| *** Improved Quality of care in health facilities through use of PDQ |
| *** Increased access to antibiotics for providers (HF, ORC as well as FCHV level) through strengthening of Community Drugs program and logistics management training for HF staff |
| *** Recognition of ARI Danger Signs at level of mothers and referral FCHV |
| *** Intensive community mobilization and BCC to enhance utilization of FCHV services |
| *** Promotion of Measles immunization |
| **Control of Diarrheal Diseases (30% in other districts and 25% in Kanchanpur)** |
| *** IMCI Integration |
| *** FCHV/MG training for home management of diarrhea |
| *** Health facility staff training for creation of ORT corners and logistical management of ORS supplies |
| *** Health facility staff training for rationale drug use for anti diarrhea |
| ***Ensure round the year availability of ORS with FCHV through CDP linkages |
| *** Community awareness and BCC campaign specially targeted at continued breast milk/fluids/food during diarrhea attacks |
| *** Community awareness and BCC campaign targeted at identification of danger signs for diarrhea cases |
| **Maternal & Newborn Care (25% in Kanchanpur)** |
| *** Promotion of ANC and maternal TT immunization |
| *** Recognition of Danger signs during pregnancy, delivery, and post partum period |
| *** Newborn Care |
| *** Post partum Care (especially maternal nutrition during postpartum period including PP Vitamin A) |
| *** Normal Delivery Care |
| *** Birth Planning |

## ATTACHMENT F. The MTE Questionnaires

### 1. Interview Guideline
**DHO/DPHO**

*Introduction: Namaste. My name is _____ . I am helping CARE Nepal, Child Survival Project for their Mid Term Evaluation. I would like to ask you some questions about your work with the project – your answers will help us to improve the project in the future. The interview will take about 45-60 minutes. All of the information that you provide will be kept confidential. Do you agree to talk to me? (if the respondent says "no", thank her and end the interview). Thank you.*

| | |
|---|---|
| Name of interviewee: | _____ |
| Age: | _____ years |
| Position: | _____ |
| Experience in that position: | _____ years |
| Overall experience in HMG: | _____ years |
| Date and time (start/end): | _____ |
| Name of Interviewer: | _____ |

Community mobilization

1. Please describe the DHO's relationship with the BAL BACHAU and the DHO's role in planning, supporting, and implementing activities in collaboration with the BAL BACHAU. What do you think about the effectiveness of this effort on improving the health of women and children in this district? How could this effort have been improved?

FCHVs

2. How capable are FCHV's in diagnosing and treating Pneumonia? How much are they utilized by the community for pneumonia treatment? How adequate is the supply of cotrim that FCHVs have? (Check record: LMIS)

3. How well have FCHVs handling diagnosis/treatment of diarrhea? How much are they utilized by the community for diarrhea management? Do they have adequate supply of ORS with them? (Check record: LMIS)

Health System Strengthening

4. In the last two years what training have you health workers and health facilities (including PHCC/HP/SHP) received? List them… What are the major changes you have observed after those trainings (Ask for some specific evidence)?

5. What purpose monthly, quarterly, annual and review meetings with Bal Bachau staffs serves? What benefits do you see from these meetings?

6. After CB-IMCI implementation in your district has the number of clients for diarrhea and pneumonia has remained same, decreased or increased? (Check: CB-IMCI recording formats)

7. After CB-IMCI implementation in your district has the number of referral case from FCHV/Mother's Groups/community/VHW/MCHW/HF for diarrhea and pneumonia has remained same, decreased or increased? (Check: CB-IMCI recording formats)

8. What is the major changes health facility management that you have observed after the formation of HFOMCs? How well are the HFOMCs able to manage their health facilities and provide support to

FCHVs? What are the specific areas that they need support to strengthen the health facility management further? (Probe: linkages and plans with local NGOs, local government etc.)

9. Please provide some information about the health facility and staff availability

| S.no | Health Facility | | Staff availability | | | CB-IMCI training status | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Category | Nos | Designation | Nos | a) Pre | Designation | Nos | Trained | Present |
| 1. | DHO | | Doctor | | | DHO | | | |
| | | | Program staff | | | DHO program staff | | | |
| | | | Admin staff | | | HA | | | |
| 2. | PHC | | Doctor | | | Staff Nurse | | | |
| | | | Program staff | | | AHW | | | |
| | | | Admin staff | | | ANM | | | |
| 3. | HP | | Program staff | | | VHW | | | |
| | | | Admin staff | | | MCHW | | | |
| 4. | SHP | | | | | FCHV | | | |
| 5. | ORC clinic | | | | | Traditional Healer | | | |
| 6. | IC clinic | | | | | VDC | | | |
| 7. | FCHV | | | | | | | | |
| 8. | TBA | | | | | | | | |

Working approach (NGO strengthening, Sustainability)

10. How CSP NGO partners are performing to improve child health situation in this district? What are the advantages and disadvantages of involving NGO partners in BAL BACHAU activities?

11. What is your plan for sustaining the activities that CS Project has initiated? What efforts have you made till date?

12. What is the magnitude of FCHV drop out in your District? What are the reasons behind the problem?

Summary

13. In your opinion, what are the major successes of the BAL BACHAU? Why?

14. In your opinion, what could be improved or done differently in the BAL BACHAU (i.e., what dd not work so well)? Why?

15. Do you have any other comments that you would like to make during this MTE of BAL BACHAU?

**Thank you for your time.**

## 7. Interview Guideline

### Health Facility In-charge

Introduction: Namaste. My name is _____. I am helping CARE Nepal, Child Survival Project for the Mid Term Evaluation. I would like to ask you some questions about your work with the project – your

answers will help us to improve the project in the future. The interview will take about 60 minutes. All of the information that you provide will be kept confidential. Do you agree to talk to me? (if the respondent says "no", thank him/her and end the interview). Thank you.

| | |
|---|---|
| Name of interviewee: | _____ |
| Age: | _____ years |
| District: | _____ |
| VDC: | _____ |
| Position: | _____ |
| Experience in that position: | _____ years |
| Type of facility: | PHCC _____ HP _____ SHP _____ |
| Years in current facility: | _____ years |
| Name of Interviewer: | _____ |

Health System Strengthening

1. What kind of trainings did you and your staffs receive through BAL BACHAU support (Probe: IMCI, HFOMC, MNH, Advocacy etc)? Aside from training, what support has the BAL BACHAU provided to you and your staff that has helped to perform jobs more effectively?

2. How useful are these trainings and other support? What changes/improvements have occurred from these efforts? How could the impacts be sustained? What is your plan and role to keep them sustained?

3. How has the BAL BACHAU helped to strengthen the capacity of the FCHVs? What are the major changes at communities after introducing BAL BACHAU (Ask for some specific evidence/example)?

4. What has been effect on BAL BACHAU support to strengthen Health Facility Operation and Management Committee? How well are the HFOMCs able to manage their health facilities and provide support to FCHVs? What support can a project like BAL BACHAU provide that would make the work of these committees more effective?

BCC

5. What are the efforts that BAL BACHAU had made to bring behaviors change at communities? How effective have these activities been in changing behavior? Which have been the most / least effective? Why? What do you think that the BAL BACHAU could do to more effectively influence behavior change among community members?

Working approach (NGO strengthening, Sustainability)

6. Please describe your the relationship to Bal Bachau NGOs (specify the name as per district) in the community health activities. When did you begin working together? What activities did you conducted in collaboration and coordination with Bal Bachau? What was the NGO's role in planning, supporting, and implementing health activities?

7. What are the advantages and disadvantages of involving NGO partners in BAL BACHAU activities? What would be your recommendations to help them to perform better?

8. What is your plan for sustaining the activities that CS Project has initiated? What efforts have you made till date? What do you expect from CARE and other stakeholders at district and above?

9. Please describe your relationship with the BAL BACHAU and your role in planning, supporting, and implementing BAL BACHAU activities. What do you think about the effectiveness of this effort on improving the health of women and children in this community? How could this effort have been improved?

10. Please provide some information about the health facility and staff availability

| S.no | Staff availability | | | CB-IMCI training status | | | |
|---|---|---|---|---|---|---|---|
| | **Designation** | **Sanctioned** | **a) Present** | **Designation** | **Nos** | **Trained** | **Present** |
| 1. | Program staff | | | PHC/HP in-charge | | | |
| | Admin staff | | | Staff Nurse | | | |
| 2. | | | | AHW | | | |
| 3. | | | | ANM | | | |
| 4. | | | | VHW | | | |
| 5. | | | | MCHW | | | |
| 6. | | | | FCHV | | | |
| 7. | | | | Traditional Healer | | | |
| 8. | | | | VDC | | | |

Supervision/Monitoring/Support

11. List the persons/authorities (designation) who visited you during last three months (Ashwin-Mangsir) (Note all supervision visits as reported by HWs and verify using the Register). How helpful were those supervision visits?

12. Are you getting any support (financial and/or in-kind) from the VDC/Municipality? If yes, what type of support are you getting? If not, why?

13. What is the magnitude of FCHV drop out in your District? What are the reason behind the problem?

*Knowledge*

14. How do you recognize a child with pneumonia?
    Fast breathing (more than 60/min for 0-2 months children and more than 50/min for 2-60 months children )
    Other (specify) _____
    Don't Know

15. How do you recognize a child with dehydration?
    Dull and sunken eyes
    Tearing
    Dry tongue
    Thirsty
    Dry/non elastic skin
    Other _____

**B. Availability of key commodities**

16. Do you currently have following items with you for distribution?

| | | | |
|---|---|---|---|
| ORS | Yes | No | If yes, how many _____ |
| Cotrim (P) | Yes | No | If yes, how many _____ |

IFA tablets Yes No If yes, how many _____

Summary

17. From your perspective, who were the "true beneficiaries" of the Bal Bachau? [Probe: to what extent did disadvantaged groups benefit from the Bal Bachau]?

18. In your opinion, what are the major successes of the Bal Bachau? Why?

19. In your opinion, what could be improved or done differently in the Bal Bachau (i.e., what did not work so well)? Why?

20. Do you have any other comments that you would like to make?

**Thank you for your time.**

## 3. Interview guideline

**MCHW/VHW**

Introduction: Namaste. My name is _____. The government and an NGO are running a Bal Bachau project in your area. We want to learn from you how the project is running so that steps can be taken to improve the project performance. We will be discussing with you for 45 – 60 minutes. All of the information that you provide will be kept confidential. Do you agree to talk to us? (if the respondents say "no", thank them and end the interview).
Thank you.

| SN | Name | VHW/MCHW | Age/Sex | VDC | Experience, yrs | | Type of facility (PHC/HP/SHP) |
|---|---|---|---|---|---|---|---|
| | | | | | Total | This HF | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |

Date and Time of Interview _____

Name of Interviewer: _____

**Community mobilization**

21. In the last three months, how many times you have interacted with FCHVs and Mother's Groups? What were the agenda discussed with them?

22. In the last one-year, you have received training from DHO/CSP on CB-IMCI and attended review meetings. Has it improved you work performance? What are the changes you have observed in improving the health of women and children? Please give examples?

**C. For Kanchanpur and some of the VDCs of other districts**

23. What is your role working with the FCHV-CC? What do you think about the work that the FCHV-CC does?

24. What support community, health facility and health facility management committee must give to FCHV-CCs, if they are to be sustained over time?

*BCC*

25. The Bal Bachau has tried to encourage members of the community to adopt healthy behaviors and seek treatment when needed through a variety of activities that include the following
    - Posters
    - pamphlets
    - listeners group of radio **(kpur only)**
    - digital broadcasting **(kpur only)**
    - training/orienting mothers, pregnant women, husbands and mothers-in-law
    - training community health workers and health facility-based workers

    How effective have these activities been in changing behavior? Which have been the most / least effective? Why?

26. What do you think that the Bal Bachau could do to more effectively to influence behavior change among community members?

Health Facility Strengthening

27. What support does the health facility receive from the VDC and members of the community? How effective is this support?

28. Do you think support from VDC/HFMC is helpful to you in providing health services? What are they? List them; … Please rate those support as good, average and poor.

*Bal Bachau in Partnership Approach*

29. Please describe your relationship to Bal Bachau NGOs (specify the name as per district) in the community health activities. When did you begin working together? What activities did you conducted in collaboration and coordination with NGOs? What was the NGO's role in planning, supporting, and implementing Bal Bachau activities?

30. There are a number of groups working with health issues in this VDC: MGs, FHCV Groups, FCHV-CC, HFOMC/HFMC. What is the role of NGO (specify name) in working with these different groups and what do you think about the work that they do? Please rate the NGO (specify names) coordination, collaboration and performance for bal bachau program?

*Monitoring and Supervision*

31. List the persons/authorities (designation) who visited you during last three months (Ashwin-Mangsir) (Note all supervision visits as reported by and verify using Register). How helpful were those supervision visits?
32. What is the magnitude of FCHV drop out in your District? What are the reasons behind the problem?

*Knowledge*

33. How do you recognize a child with pneumonia?
    Fast breathing (more than 60/min for 0-2 months children and more than 50/min for 2-60 months children )
    Other (specify) _____
    Don't Know

34. How do you recognize a child with dehydration?
    - Dull and sunken eyes
    - Tearing
    - Dry tongue
    - Thirsty
    - Dry/non elastic skin
    - Other _____

*CB-IMCI*

35. After CB-IMCI implementation in your Health Facility, has the number of clients for diarrhea and pneumonia that you treat has remained same, decreased or increased? (Check: CB-IMCI recording formats)
36. After CB-IMCI implementation in your Health Facility, has the number of referral case from FCHV/Mother's Groups/community for diarrhea and pneumonia has remained same, decreased or increased?

*Sustainability*

37. How is the Community Drug Program going in this VDC? Please describe the strengths and weaknesses of the program. **(Ask only in Kanchanpur)**

38. HFOMC have four primary areas where they can have an impact on improving the availability of medicines & supplies (cotrim, JJ, blue plastic cup, iron tabs. Etc.) For each of the following points, please comment on the impact that the HFOMC has had in your VDC. If impact has been low, please comment on how impact could be improved:
    - Maintain constant medicine (cotrim, JJ, blue plastic cup, iron tabs. etc.) and supplies required
    - Cotrim fund are established and functioning to manage the year round availability.

*Summary*

39. In your opinion, what are the major successes of the Bal Bachau? Why?

40. In your opinion, what could be improved or done differently (i.e., what did not work so well)? Why?

41. Do you have any other comments that you would like to make?

## 4. Interview Guideline

**Partner NGOs**

Introduction: Namaste. My name is _____ . I am helping CARE organization evaluate the health project that they are supporting in Kanchanpur district. I would like to ask you some questions about how your NGO worked with the project – your answers will help us to improve the project in the future. The interview will take about 45-60 minutes. All of the information that you provide will be kept confidential. Do you agree to talk to me? (If the respondent says "no", thank them and end the interview). Thank you.

| | |
|---|---|
| Name of interviewee: | _____ |
| NGO: | _____ |
| Position: | _____ |
| Experience in that position: | _____ years |
| Date and time: | _____ |
| Name of Interviewer: | _____ |

*Community mobilization*

1. Please describe the relationship of your NGO with the Project. When did you begin working together? What activities do you conduct in the BAL BACHAU? What was your NGO's role in planning, supporting, and implementing BAL BACHAU activities?

2. There are a number of groups working with health issues in this VDC: MGs, FHCV Groups, FCHV-CC, CHMC, and HFOMC/HPMC. What is your role in working with these different groups (some examples of different role that HFs/BAL BACHAU staffs are suppose to do)?

Capacity Building

3. How has your NGO's capacity changed through your partnership with CARE (probe: trained manpower, physical infrastructure, linkage building, organizational management etc.)?

4. What types of organizational capacity assessments of your NGO (either formal or informal) have been conducted by or in partnership with CARE? How have you acted on the results of the assessments?

5. What kinds of training did you and your staffs receive through BAL BACHAU support to help you do your work effectively?

6. How useful has the training been for you to do your job? What skills did you learn?

7. How could the training be improved?
8. Aside from training, how has CS supported the strengthening of individual staff members' skills? Please provide some examples of how your staff's performance level has changed through your partnership with CARE and BAL BACHAU.

9. What has been the most / least effective support that CARE has provided to your NGO with regarding to building capacity?

Sustainability

10. As you know, the BAL BACHAU will be reducing the support gradually. Please tell me which activities that your NGO conducts / supports will continue even after the BAL BACHAU is gone, and which activities will be difficult to conduct if the BAL BACHAU withdraws its support.

11. Please describe any plans that you have to continue BAL BACHAU activities that your NGO has conducted until now after the BAL BACHAU phase out? Did your NGO / BAL BACHAU work together to develop explicit plans for your NGO to continue CS activities after the end of the Project?

12. How could the partnership between CARE and your NGO be improved in the coming days of the BAL BACHAU? (Probe: improving working environment, enhancing organizational capacities both in program management capacities as well as organizational management capacities, improving coordination/partnership between stakeholders)

13. How does your NGO plan to compensate for the coming decrease in financial support from CARE? (probe: what plans do you have to diversify external funding sources?)

Summary

14. From your perspective, who were the "true beneficiaries" of the BAL BACHAU? [probe: to what extent did disadvantaged groups benefit from the BAL BACHAU]?

15. In your opinion, what are the major successes of the BAL BACHAU? Why?

16. In your opinion, what could be improved or done differently in the BAL BACHAU (i.e., what did not work so well)? Why?

17. How do you coordinate your work between BAL BACHAU/DHO and NGOs? What are systems/tools and/or mechanisms that you are practicing now for synergy in your collective work? Any thing that is not working well in your opinion and need to be improved in coming days, if yes give examples/suggestion?

18. In your opinion: How the DHO perceives your contribution in overall district health program and particularly in BAL BACHAU? How the DHO need to support in your work?

19. Do you have any other comments that you would like to make?

## 5. Interview Guideline

### Project Advisory Committee

*Introduction: Namaste. My name is _____ . The government and an NGO are running a Bal Bachau project in your area. We want to learn from you how the project is running so that steps can be taken to improve the project progress. We will be discussing with you for 30 – 45 minutes. All of the information that you provide will be kept confidential. Do you agree to talk to us? (if the respondents say "no", thank them and end the interview). Thank you.*

***D.*** **Project Advisory Committee:** ***District:***_____ ***'or'*** ***Region:*** _____

| S.no | Name of PAC member | Age (yrs.) | Designation | Experience year in that post (yrs.) | PAC position |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |

Name of interviewer: _____ Date: _____

**General – PAC committee**

1. When was the PAC committee formed?

2. What is the purpose of PAC? Did PAC committee received orientation on Bal Bachau project?

3. How often PAC meetings are held? How is the meeting agenda identified? What are the issues discussed? Tell us of a few important decision made.

4. What are roles of PAC is (if there is more than one response write all), in Bal Bachau project?

**Project goal, strategy and working approach**

Ministry of Health, Social Welfare Council and CARE-Nepal are jointly implementing Bal Bachau in Far West (Child Survival XIX), a four-year program to support health systems in Kanchanpur, Doti, Dadeldhura and Bajhang districts. The project goal is contribute to improve the health of children (under age five) and pregnant and lactating mothers as part of the strategy to improve household livelihood security in the four districts. Project objectives are;

- *Access to service and supplies*
- *Quality of care*
- *Behavioral change*
- *Local capacity building*

5. In your view do the goal, strategy and objectives of Bal Bachau are synchronized to get the desired result?

6. Are the project goals, strategies and working approaches compatible with the current situation? If yes how? /if not, what does it needs modification (overall and specifically)?

7. Are the project strategies and working approaches sound enough to improve the child mortality and morbidity in the project districts? If not, in what ways these need to be modified?

**Sustainability – Access to service and supplies**

8. In your opinion, the project is going in the right direction to increase and sustain the accessibility of health services and supplies at community level? Currently what components of project are weak? How can these strengthen?

9. In relation to the project, what are the government roles and responsibilities to sustain the accessibility of service and supplies at the community level?

10. In what and how the project can complement the government and community to increase and sustain the health services and supplies at community level?

**Sustainability – Quality of Care**

11. CARE has committed to improve the quality of following Bal Bachau activities, how do you rate these
    - Capacity building _____
    - Monitoring & evaluation _____
    - Recording & reporting _____
    - Supplies availability _____

12. In regard of sustainable quality of care, what should be the government roles and responsibilities, how they are functional today?

13. What are the issues and challenges that hinders and quality of care? How they can be collectively solved?

**Sustainability – Behavioral Change**

14. How is the project contributing to positive behavioral change in community?

15. What the areas of strategic improvements to be done for next two years by the project and government health functionaries?

**Sustainability – Building Local Capacities**

16. What are the areas of project to build the local capacities? Give examples; … How the project is performing its activities?

17. Is the way of doings' are good enough to build local capacities that will be within the DIP and proposal - what are the areas to be strengthen that helps to sustain child health activities beyond the project period?

**E. Monitoring and Supervision**

18. How often the PAC goes to field sites (project sites or partner organization or government health functionaries) for monitoring and supervision jointly? If field visit, what were the major findings? What were the suggestions made to project, partners and government itself?

19. Is the project is maintaining its quality of work via supervision and monitoring? Is there any area of improvements? If yes, what are they? And how?

**Summary**

20. From your perspective, who were the "true beneficiaries" of the BAL BACHAU? [Probe: to what extent did disadvantaged groups benefit from the BAL BACHAU]?

21. In your opinion, what are the major successes of the BAL BACHAU. Please elaborate?

22. In your opinion, what could be improved or done differently in the Bal Bachau (i.e., what did not work so well)? Why?

23. Do you have any other comments that you would like to make?

## ATTACHMENTG. Training Details

**Table A. Number of MOH staff and FCHVs trained in Clinical and CB-IMCI by the CSP till MTE (Jan 2006)**

| District | Training type | Status | Batch/ Participant | IMCI Clinical | | | | Community level IMCI training | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Clinical (MToT) | Clinical | Supervisor | | Magt. ToT | 2 day Magt | VHW/ MCHW/FCHV | Total |
| Doti | Clinical | Completed | Batch | 1 | 3 | 1 | **5** | | | | |
| | | | DHO (HA, SN, AHW & ANM) | 7 | 49 | 6 | **62** | | | | |
| | | | Partners/CS | 1 | 11 | 3 | **15** | | | | |
| | Community | C | HA, SN, AHW & ANM | | | | | 16 | 72 | - | **88** |
| | | C | VHW/MCHW | | | | | - | - | 90 | **90** |
| | | O | FCHV | | | | | - | - | 172 | **172** |
| Dadeldhura | Clinical | Completed | Batch | 1 | 2 | 1 | **4** | | | | |
| | | | DHO (HA, SN, AHW & ANM) | - | 41 | 6 | **47** | | | | |
| | | | Partners/CS | - | 6 | 2 | **8** | | | | |
| | Community | C | HA, SN, AHW & ANM | | | | | 10 | 51 | - | **61** |
| | | C | VHW/MCHW | | | | | - | - | 37 | **37** |
| | | O | FCHV | | | | | - | - | 322 | **322** |
| Bajhang | Clinical | Completed | Batch | 1 | 3 | 1 | **5** | | | | |
| | | | DHO (HA, SN, AHW & ANM) | 11 | 51 | 6 | **68** | | | | |
| | | | Partners/CS | - | 4 | - | **4** | | | | |
| | Community | C | HA, SN, AHW & ANM | | | | | 12 | 28 | - | **40** |
| | | C | VHW/MCHW | | | | | - | - | 75 | **75** |
| | | P | FCHV | | | | | - | - | - | **-** |
| Kanchanpur | Clinical | Completed | Batch | - | 1 | - | **1** | | | | |
| | | | DHO (HA, SN, AHW & ANM) | - | 20 | - | **20** | | | | |
| | | | Partners/CS | 1 | 2 | 1 | **4** | | | | |
| **Grand Total** | | | | 20 | 184 | 24 | 228 | 38 | 151 | 696 | 885 |

**Table B. Number of Mothers Group and FCHVs groups strengthened by CSP till MTE January 2006**

| Activity | Target | Achievement |
|---|---|---|
| **Mothers Group** | | |
| Develop Norms for MGs meetings | Norms developed | Activity completed |
| Orientation to MG on effective group meeting | 674 MG | 100% |
| | | |
| **FCHVs** | | |
| LRP training | 79 | 100% |
| Cross visits to Kanchanpur | 21 | 100% |
| Effective group meeting orientation | 23 groups | 100% |
| Joint monitoring | 152 clinics | 100% |
| Support on quarterly review meeting | 42 groups | 100% |

**Table C. Child Survival Project Training for Fiscal Year 2004-2005**

## Compiled Sheet of Trainings for CSP FY 2004-05

| Name of Training | Objectives | Duration | No. of Participants | | | | Facilitators | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | DHO | Pos | BBA | Total | DHO | Pos | BBA | CO | Consul | Total |
| Pre-service training | 1.To orient participants on Child Survival project 2.To create common understanding by detailed discussion on Child Survival Project 3.To provide knowledge and skill for quality program implementation | 7 days | 0 | 22 | 7 | **29** | 1 | 0 | 6 | 0 | 0 | **7** |
| Right Based Approach and Advocacy Training | 1. To help participants analyze fundamental human rights and its context in social structure 2. To assist participants in identifying evidence based issues for advocacy | 5 days | 0 | 0 | 7 | **7** | 0 | 0 | 1 | 4 | 0 | **5** |
| Performance Management Training | To revise the system of previous Performance Appraisal Review (PAR) | 3 days | 0 | 0 | 7 | **7** | 0 | 0 | 0 | 3 | 0 | **3** |
| BCC Workshop | 1. To increase the understanding of the participants on the concept, scope, and application of BCC in CS projects 2. To prepare the draft of the BCC strategy paper | 6 days | 0 | 0 | 14 | **14** | 0 | 0 | 0 | 0 | 1 | **1** |
| CSP all staff meeting | 1. To share and review the district progress 2. To share concepts of district-specific initiatives | 2 days | 0 | 0 | 26 | **26** | 0 | 0 | 4 | 1 | 0 | **5** |
| FGD on Right Based Approach | 1. To assess understanding of CARE Nepal's staffs on RBA 2. To collect views of the participants to adopt RBA in current approaches | 1 days | 0 | 2 | 13 | **15** | 0 | 0 | 0 | 1 | 2 | **3** |
| LQAS Training | 1. Participate in LQAS survey methodology 2. Be able to analyze results | 3 days | 43 | 21 | 20 | **84** | 0 | 0 | 2 | 0 | 0 | **2** |
| ISP Workshop | 1. To collect participant views on the 3 year intermediate strategic plan development | 3 days | 1 | 2 | 3 | **6** | 0 | 0 | 0 | 1 | 2 | **3** |
| HMIS training by GTZ | To learn about MoH HMIS | | 0 | 0 | 8 | **8** | | | | | | **0** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LRP training to FCHV | 1. To orient participants on national FCHV Program<br>2. To develop skilled facilitators to increase accessibility and quality of local service centers | 5 Days | 79 | 0 | 0 | **79** | 0 | 4 | 3 | 0 | 0 | **7** |
| LRP review workshop | Review information and reinforce lessons learned | | 18 | 0 | 0 | **18** | 2 | 2 | 3 | 0 | 0 | **7** |
| Do No Harm Workshop | 1. To make the CSP staffs develop the skills for identifying probable steps to implementing program activities in conflict-influenced areas | 2 days | 0 | 0 | 22 | **22** | 0 | 0 | 0 | 1 | 0 | **1** |
| Public Rights and Advocacy Training | 1. To orient participants on analyzing and identifying social issues through REFLECT model<br>2. To help the participants learn different right based tactics through evidence based experience sharing | 6 days | 5 | 46 | 26 | **77** | 0 | 0 | 0 | 0 | 2 | **2** |
| PD Hearth Orientation | 1. To orient DPHO/CSP and partners on PD hearth concept for starting the PD Hearth session | 7 days | 0 | 3 | 8 | **11** | 0 | 0 | 0 | 1 | 0 | **1** |

**Attachment H. District BCC Strategy**

**Expected outcomes from the BCC related activities**

| SN | Behavior | Stage |
|---|---|---|
| **A** | **Immunization** | |
| 1 | Mother take their children for complete routine immunization | Contemplation |
| **B** | **Physical growth nutrition** | |
| 2 | Children age 6-59 month receive vitamin A supplement at a interval of 6 month | Maintenance |
| 3 | Under 3 years children mother will take their children for regular growth monitoring | Awareness |
| 4 | Each HH consume iodized salt focused to reproductive age group mother | Contemplation |
| 5 | Mother practicing EFB for 6 month | Adoption of new practice |
| **C** | **CDD/ARI** | |
| 6 | Mother recognize two danger signs of pneumonia requiring medical treatment | Awareness |
| 7 | Mother visit children under 2 years who seek medical care from a trained provider (DHO, HP, SHP, trained | Contemplation |
| 8 | FCHVCC) for their children with two danger sign of pneumonia (fast or difficult breathing) | Intention |
| 9 | ✓ Under 5 children were given the same or more breast feeding/fluid during diarrhea<br>Under 5 children with diarrhea were treat with ORS | Trail of new practice |
| 10 | Mother practicing hand washing with soap before preparing food feeding the children and after defecation. | Intention |
| **D** | **Family health** | |
| 11 | MWRAG- practice birth spacing of at least 3 years. | Awareness |
| 12 | Pregnant women have at least 4 ANC | Awareness |
| 13 | Delivery conducted by trained health worker (MCHW. ANM, Staff Nurse, HA, AHW, Dr) | Contemplation |
| 14 | Women receive Vitamin A supplementation within 42 days of postpartum | Intention |
| 15 | SDK will be used during every delivery at home | Contemplation |
| 16 | Pregnant mother consume IFA tablets and single doze of Alben from 4th month of pregnancy till the (45) days postpartum | Intention |
| **E** | **Disease control** | |
| 17 | People with cough longer than 2 weeks visit health facility for examination of TB | Awareness |
| 18 | People with anesthetic patch visit HG for examination of leprosy | Awareness |

| | | |
|---|---|---|
| 19 | Under 5 children and pregnant women sleep under mosquito met, ITN and LLIN for malaria prevention | Awareness |
| 20 | Every cases of fever will visit HF with in 24 hrs. of fever onset | Awareness |
| 21 | People will use condom during unsafe sex with multiple partner | Awareness |

| A. Immunization<br>**1. Mother takes her children for complete routine immunization**<br>**Sate: Contemplation** | |
|---|---|
| **Monitoring & Evaluation** | LQAS to evaluate the coverage<br>Observation visit to EPI clinics to monitor counseling<br>No of session taken by FCHV and number of lactating and pregnant mother's house visited<br>Routine functioning of the EPI clinics<br>Regular meeting of EPI committee<br>IEC material development its testing and dissemination |
| **Activities** | Counsel to the guardians by Health facilities staff and community level health worker.<br>Orientation to the mother through FCHV during MG meeting and HH visit<br>Mobilization of Immunization committee for awareness and proper management of the EPI clinics<br>Collection of EPI, IEC material and distribution<br>Orientation to health worker for update recording<br>Mobilize mobile MG meeting to cover those mother whoa re not included in MG |
| **Channel** | IPC<br>Group counsel-ing<br>Poster<br>Local channel |
| **Messages** | Complete immunization prevent from 7 major killer disease to baby<br>Mild fever after vaccination does not harm the child but is normal symptom<br>On (given) date there is EPI clinics so please visit for getting your child immunization |
| **Audience** | Mother and guardian of under 1 year children<br>Community people<br>Health worker |
| **Barriers** | Lack of awareness<br>Older age of vaccine-tion<br>Lack of Poor counseling to mother |
| **Feasible Behavior** | All mothers take their children to routine immunization. |
| **Current Behavior** | 75% children complete routine immunization |
| **Ideal behavior** | Mother take their < 1 year for complete routine immunization |

| B. Physical Growth Nutrition<br>1. Children age 6-59 months receive Vitamin A supplement at an interval; of 6 months<br>Stage: Maintenance<br>2. Under 3 years children mother will take their children for regular growth monitoring<br>Stage: Awareness | |
|---|---|
| **Monitoring & Evaluation** | No of (%) increase in GM child<br>Session of orientation by FCHV to MG<br>Functional GM in PHC ORC<br>Availability of WM and MUAC at health facilities and FCHV<br>No of pregnant and lactating mother identified and oriented on GM |
| **Activities** | Health child exhibition<br>FCHV and mothers group mobilization to orient mother for GM to their child<br>GM service in PHC ORC<br>Adequate supply of WM/ MUAC tape<br>Identification of pregnant/lactating mother and counseling them for GM. |
| **Channel** | Mass communication<br>IEC<br>Street drama<br>IPC<br>Audio/video media |
| **Messages** | Regular growth monitoring will help you to identify the status of your children and help you for timely action<br>Regular G.M. prevents your child from malnourishment<br>GM also help you to know any deviation of your child health status and disease |
| **Audience** | Mothers of children and family members |
| **Barriers** | Lack of service |
| **Feasible Behavior** | Measurement (GM) through FCHV using MUAC |
| **Current Behavior** | Irregular growth monitoring of children (during vaccination) |
| **Ideal Behavior** | Routine growth monitoring of children under 3 years |

| II. Each HH consume iodized salt focused to reproductive age group mother<br>Stage: Contemplation | |
|---|---|
| **Monitoring & Evaluation** | Selection of salt for demonstration, and method of demonstration<br>Orientation of mother group by trained person and number of orientation session taken and the participants<br>Orientation to the local salt Dipo and the changes in storing of salt by them<br>Message designed tested and disseminated by local media |
| **Activities** | Iodized salt demonstration<br>Orientation to Mother, care taker and household decision maker on IODINE<br>MG orientation through FCHV<br>Orientation to salt dipo and local businessman about storing salt and preservation of iodine.<br>Mass communication through local FM and radio |
| **Channel** | Poster/pamphlet<br>Mass communication<br>IPC |
| **Messages** | Use two baby photo stamped salt<br>Placing salt near heat and open pot will destroy the iodine content of your salt<br>Don't wash salt during cooking and place salt in food during the end of cooking.<br>Iodine will prevent you from Goiter / mental retardation |
| **Audience** | **Primary** Household decision maker and mother who cook<br>**Secondary**<br>Whole of the community and local businessman |
| **Barriers** | Open border<br>High cost of packet salt<br>Unavailability of packet salt every where<br>Lack of knowledge |
| **Feasible Behavior** | Use iodized dhike salt from slat trading with precaution measure of protecting iodine in Dhike salt |
| **Current Behavior** | Use of non iodized salt (Dhike salt) |
| **Ideal Behavior** | Consume iodized salt by all family members |

| III. **Mother practicing EBF for 6 months**<br>**Stage: Adoption** | |
|---|---|
| **Monitoring & Evaluation** | Number of orientation session conducted<br>Selection of healthy baby and session of demonstration conducted<br>No of class taken by FCHV during MG meeting<br>Type of video demonstration and the target audience<br>Types of IEC material developed tested and disseminated<br>No of mobile MG meeting conducted |
| **Activities** | Orient mother group through FCHV<br>Healthy baby demonstration<br>FCHV mobilize for IPC<br>Encouraging mothers through HF and municipality clinics<br>Video show during mother group meeting or EPI clinics<br>Cover and orient dispersed mother group thorough mobile MG meetings. |
| **Channel** | Local channel/media<br>Posters<br>Exhibition<br>Hoarding board<br>Video show<br>IPC |
| **Messages** | Exc. breast feeding promote baby physical growth and development and EBF Prevents from diseases<br>No cost way for healthy baby<br>Increase relation between mother and baby<br>Sucking increases breast milk and beauty |
| **Audience** | Lactating and pregnant Mothers and fathers |
| **Barriers** | Ignorance<br>Lack of protein diet to mother<br>Urbanization<br>Low birth spacing |
| **Feasible Behavior** | Practice exclusive breast feeding if not able to do so due to other reason practice animal milk rather than that of artificial milk. |
| **Current Behavior** | Majority of the mother practice breast feeding but in combination with supplementary feeding |
| **Ideal Behavior** | Practice Exclusive breast feeding for 6 month |

| C. CDD/ARI<br>Mother recognize two danger signs of pneumonia requiring medical treatment<br>(Stage: Awareness**)** | |
|---|---|
| **Monitoring & Evaluation** | No of (%) of mother who recognizes two danger sign of pneumonia<br>Orientation and awareness session conducted by FCHV<br>No of Dhami Jhakari oriented and trained<br>Number of mother covered through mobile mother group meeting |
| **Activities** | Orientation of MG through FCHV<br>Orientation Parents through FCHV<br>FCHV mobilization and household visit to awareness raising<br>Orient Dhami/ jhakari on symptoms of pneumonia<br>Intensive mother orientation through mobile Mother's Group meeting. |
| **Channel** | Video show<br>Demonstration<br>IPC |
| **Messages** | Fast breathing is symptom of pneumonia and hence consult FCHV for treatment<br>If your child has suffering from difficult breathing it might be pneumonia and you need to treat urgently.<br>Consult FCHV in common cold |
| **Audience** | Mother of reproductive age group or with children |
| **Barriers** | Lack of knowledge<br>Traditional behavior<br>Many children<br>Dispersed community and household |
| **Feasible Behavior** | All mother recognized at least one danger sign |
| **Current Behavior** | 75 % mother recognized two danger sign of pneumonia |
| **Ideal Behavior** | Mother recognized at least two danger sign of pneumonia |

| IV. Mother visit children under 2 years who seek medical care from a trained provider (DHO, HP, SHP, trained FCHVCC) for their children with two danger sign of pneumonia (fast or difficult breathing**)**<br><br>**(Stage: Contemplation)** | |
|---|---|
| **Monitoring & Evaluation** | No of cases reported by FCHV and the cases referred to HF by FCHV<br>No of education session taken by FCHV to MG<br>No of drug retailer oriented on IMCI and referring child to HF<br>Conduction of mobile MG meeting to dispersed houses mother focus on dalit<br>IEC material collected tested and disseminated |
| **Activities** | Orientation to Dhami Jhankri child health (major diseases)<br>Orient MG through FCHV<br>Regular supply of materials to FCHV for treatment under IMCI program<br>Orient drug retailers so that they will refer the child to HF once brought to them<br>Disseminate awareness to those mothers who are not covered into the Mother Groups by mobile mother group meeting. |
| **Channel** | Mass communication<br>IPC<br>Video<br>Flipchart/poster |
| **Messages** | FCHV is well trained at your community who will provide cure and suggestion to your sick child.<br>Visit FCHV on the first hand your child get sick<br>If you won't able to meet FCHV please take your child to near by HF |
| **Audience** | Mother father Traditional healer |
| **Barriers** | Lack of knowledge on consequences of not getting timely cure<br>Traditional believes<br>Dominate female child |
| **Feasible Behavior** | Consult at least FCHV as soon as possible during the child get sick |
| **Current Behavior** | Some of the Sick children are taken traditional healer for cure |
| **Ideal Behavior** | Sick child under 2 years of age get medical care from trained health service provider |

| V. Under 5 children were given the same or more breast feeding/fluid during diarrhea<br>Stage: Intention | |
|---|---|
| **Monitoring & Evaluation** | Counseling conducted by trained health workers<br>Decrease in sever dehydration cases in HF<br>Proper IEC used for demonstration<br>No of MG oriented<br>No of caretaker oriented by trained HW |
| **Activities** | Counseling to mother<br>IPC through MG and FCHV<br>Demonstration of ORS in community<br>MG orientation<br>Orientation to caretaker on the preventive measures during diarrhea |
| **Channel** | Demonstration<br>IPC |
| **Messages** | There is no alternative of breast milk to save life your children during diarrhea<br>Provide sufficient fluid during diarrhea to prevent from getting child dehydrated |
| **Audience** | Mother and caretaker |
| **Barriers** | Traditional believes<br>Lack of knowledge |
| **Feasible Behavior** | The mother will give more BF or fluid to child during diarrhea |
| **Current Behavior** | Many of the community people won't give fluid or sufficient breast milk during diarrhea |
| **Ideal Behavior** | Under 5 children given same or more fluid / BF during diarrhea |

| VI. Under 5 children with diarrhea were treat with ORS<br>(Stage: Trail of new practice) | |
|---|---|
| **Monitoring & Evaluation** | No. of diarrhea case treat with ORS<br>Demonstration session conducted through trained health worker<br>No of Dhami Jhakari oriented<br>Message production/ testing and distribution<br>Cover of isolated mother through mobile MG meeting |
| **Activities** | Orient Mother group through FCHV<br>Demonstration of ORS use and its benefits by FCHV during MG meeting and HH visit<br>Orientation to Dhami / Jhakari on the use of ORS<br>Awareness raising through mobile mother group meeting<br>IEC production / testing and disseminations |
| **Channel** | Audio/Video<br>Hoarding board<br>IPC<br>IEC |
| **Messages** | Diarrhea can kill your baby if not given with ORS<br>ORS will protect your child from getting dehydration<br>Diarrhea causes dehydration and only ORS can safe the life of your baby. |
| **Audience** | **Primary**<br>Mother and father of children<br>Caretaker<br>**Secondary**<br>Community people |
| **Barriers** | Lack of knowledge<br>Unavailability of ORS<br>Lack of BPC<br>Traditional believes |
| **Feasible Behavior** | All the < 5 years children treated with ORS during diarrhea |
| **Current Behavior** | Low use of ORS<br>Plain water used during diarrhea |
| **Ideal Behavior** | Under 5 children with diarrhea were treated with ORS |

| VII. Mother practicing hand washing with soap before preparing food feeding the children and after defecation.<br>Stage: Intention | |
|---|---|
| **Monitoring & Evaluation** | Session conducted in school health program<br>MG orientation by FCHV during meeting and HH visit<br>No of dirking water hand pipe installed<br>Production of IEC material in local language, its testing and dissemination to the target audience. |
| **Activities** | School health program<br>Orientation MG/ community member through FCHV<br>FCHV mobilization and awareness during HH visit<br>Coordination with concern office for water supply and toilet<br>Production of IEC material it testing and dissemination. |
| **Channel** | Poster<br>Street drama<br>Demonstration<br>IPC |
| **Messages** | Hand washing prevents diseases like diarrhea<br>Wash your hand before taking food or feeding your child and after defecation.<br>Wash your hand with soap if not with Kharani (Ash)<br>Prevents mortality |
| **Audience** | All community people<br>Mother and care-taker |
| **Barriers** | Coast of soap<br>Lack of knowledge |
| **Feasible Behavior** | At least Kharani should be used appropriate hand washing before feeding and after defecation |
| **Current Behavior** | Soap is not used for hand washing<br>Most of women and people won't wash hand but some women use Soil for hand washing rather than soap. |
| **Ideal Behavior** | Mother practicing appropriate hand washing practice with soap/ Kharani before food cooking and feeding and after defecation |